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A CHECKUP ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON FEDERAL SERVICES,
POST OFFICE, AND CIVIL SERVICE

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

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A CHECKUP ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FRIDAY, APRIL 20, 1990

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL SERVICES,
POST OFFICE AND CIVIL SERVICE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:35 a.m., in room SD-342, Dirksen Senate Office Building, Hon. David Pryor, Chairman of the Subcommittee, presiding.

Present: Senators Pryor and Stevens.

OPENING STATEMENT OF SENATOR PRYOR

Senator PRYOR. Good morning, ladies and gentlemen. We welcome you all to this hearing. This morning, our witnesses will discuss the Federal Employees Health Benefits Program (FEHBP) and the need for reform of the system. The Office of Personnel Management (OPM) and the Congressional Research Service (CRS) have issued reports which outline the problems with the health benefits program. Adverse selection, wide variations in the ratio of the cost of the benefits to the value of the benefits, and the need to address the circumstances of retirees who are eligible for Medicare are thorny problems which have no simple solution. While medical costs have skyrocketed for everyone in our country, the current design of the Federal Employees Health Benefits Program may be exacerbating problems. In addition, the Medicare catastrophic legislation also brought to light issues specific to the retirees in the program.

The private sector is exploring a number of ways to control costs. While these are worth considering, I believe we must be very, very careful not to shift the cost of health care from the Government to the participants in the plan. We will also discuss the Administration's budget proposals with Ms. Newman, the Director of OPM. The Administration proposes saving some $850 million from health benefits reform. I realize that each year it becomes harder to find funds to enable us to reduce the deficit, but I am very leery of any proposal that would shift the cost entirely from the Government to the employees and the retirees. Ms. Newman will also provide some details regarding OPM's reform proposal.

Another matter I hope to explore is the implementation of OPM's "call letter" recently sent to the insurance carriers, proposing a 21-month contract period. Putting the Federal Employees

Health Benefits Program on the same schedule as the Federal fiscal year is the reason given by OPM for this change. However, I think there are several questions that remain. For example, will the open season continue to be held two months before the premium year starts? It also raises questions about the premium calculations. Last year Congress enacted legislation to address the situation created when Aetna dropped out of the program. It is not clear whether OPM intends this "call letter" to supersede that legislative fix and reduce the Government's contribution to the premium.

As Congress discusses and goes forward with reform and as this year's budget proposals of the Administration come forward, hopefully, concern for the Federal employee and the retiree will continue to guide our policies. Once again, there are no easy solutions or answers, but we look forward this morning to hearing our first witness, Ms. Constance Newman, Director of the Office of Personnel Management.

Ms. Newman, we welcome you. You are no stranger to this Subcommittee. I have been informed that Senator Stevens will be with us this morning, and, perhaps, Senator Wilson.

Ms. Newman, we welcome you.

TESTIMONY OF CONSTANCE BERRY NEWMAN, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT,[1] ACCOMPANIED BY CURTIS J. SMITH, ASSOCIATE DIRECTOR, RETIREMENT AND INSURANCE GROUP

Ms. **Newman**. Thank you very much, Mr. Chairman. I have with me today Mr. Curt Smith, who is the Associate Director for the Retirement and Insurance Group.

Senator **Pryor**. Mr. Smith, we welcome you.

Ms. **Newman**. We have agreed that I will answer the easy questions, and he is going to take the tough ones.

Senator **Pryor**. He will take the tough ones.

Ms. **Newsman**. Yes. Thank you very much, Mr. Chairman, for giving me this opportunity to discuss further the recommendations that the Office of Personnel Management recently submitted to Congress concerning near and long-term strategies for improving the Federal Employees Health Benefits Program. We welcome discussion of what basic program structure would best serve Government and enrollee interests in terms of equity for all segments of the enrollee population, cost efficiency, and maintaining appropriate Government-enrollee cost-sharing.

Mr. Chairman, I will submit my full statement for the record and just move quickly past some parts of it.

Senator **Pryor**. Thank you for doing that, Ms. Newman.

Ms. **Newman**. For nearly 20 years following the FEHB program's inception in 1960, it was essentially stable and afforded most enrollees a satisfactory choice among insurance alternatives providing very comprehensive protection against health care expenses. However, in the late 1970s, as the number of plans increased and national health care costs escalated rapidly and annuitants came to represent a significant percentage of the program enrollees, inherent structural problems began to surface.

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[1] See p. 33 for Ms. Newman's prepared statement.

As indicated in our March 1 letter,[1] the Administration proposes two options: either to stabilize Government expenditures by using a program-wide weighted average formula for determining its contribution under the program, or—and this is for fiscal year 1991—or to adopt a combination of legislative and administrative initiatives. Both methods would reach the fiscal year 1991 budgetary savings target of $850 million.

As described in our March 1 letter, the weighted average formula would substitute, as a cap on the maximum dollar amount the Government would contribute to each employee's plan, 60 percent of the weighted average of all plans in place of 60 percent of the simple average of the "Big Six" carriers. Today the original "Big Six" approach no longer reflects actual usage. The weighted average approach better reflects the original intent of the legislation. The use of the weighted average formula in fiscal year 1991 would achieve $850 million in savings.

In addition, we have also proposed an alternative mix of legislative and administrative initiatives which could also achieve the $850 million in savings while directly benefiting enrollees. This second alternative anticipates 3 legislative actions: First, preemption of state premium taxes; second, unification of the Treasury-held contingency reserves;. and third, changing the Government contribution formula from 60 percent of the "Big Six" to 67 percent of the program-wide weighted average rates.

In addition, we are proposing a number of administrative changes: requiring all plans to ensure that proper benefits coordination takes place in cases where both Medicare and FEHB benefits apply, and mandating that all participating plans adopt appropriate cost containment measures, such as large-case management. And in addition, we would be providing for assessment of the effectiveness of each FEHB plan's cost containment techniques and Medicare coordination, and that assessment would be reflected in the profit charges accorded to each carrier.

Over the long term, Mr. Chairman, we do believe that there is a need for comprehensive reform, reform that would require a change in the structure. We have outlined to you in our letter of March 1 that we were interested in building distinct risk pools for employees and annuitants. Benefit levels, premiums, and Government contributions would vary between the risk pools. Employees would have a choice among a limited number of Governmentwide self-insured indemnity plans providing basic and/or supplemental benefits appropriate for that group. Retirees would be covered by Medicare and a medigap plan which would fill in the copayments and the deductibles not covered by Medicare, permitting full payment of charges up to Medicare's approved amount.

Any retiree over age 65 without automatic Medicare eligibility would be afforded an opportunity to elect voluntary Medicare enrollment and combine this with a medigap coverage. Retirees under age 65, and those over age 65 who might not wish to participate in the Medicare program, would be provided essentially the same level of coverage as their Medicare-eligible counterparts under an alternative plan.

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[1] See p. 75.

We have laid out the basic structure of our plan in my March 1 letter, but many of the details on the benefits are yet to be provided. There is a White House Task Force on the Federal Employees Health Benefits Program which has been commissioned to study state-of-the-art health benefits structures and, in addition, to look at cost containment mechanisms. And it was our belief that it is extremely important for us first to resolve the structure question, and as we are doing this, this task force will continue to work on the nature of the benefits structure.

My prepared statement goes more into what will happen during the transition period, but now, Mr. Chairman, I look forward to answering your questions.

Senator PRYOR. Thank you very much, Ms. Newman. You talked about two options that the Administration is considering. One is the weighted average system that you described, and the second option, is a mix of legislative and administrative initiatives. Now, this all sounds good. What does this mean to the average Federal employee out there? Does that mean increased premiums?

Ms. NEWMAN. It does not mean increased premiums. As a matter of fact, if we use the combination of our administrative and legislative actions, it will reduce the premiums by $100 million. So, what we are talking about doing is coming up with savings, and we are concerned, Mr. Chairman, about the increased costs of health care, and as a large employer we have to take that into consideration. We have an obligation, as you know, to the taxpayers, but we are also concerned about providing benefits which will allow us to compete with the private sector.

Senator PRYOR. Would the benefits of the average Federal employee be diminished?

Ms. NEWMAN. The benefits would not under this proposal. Now, we also recognize that health care costs are increasing, so that to be honest—and I think I will ask Curt to correct me on this—this $100 million will pretty much equal the increase in the costs this year, the natural costs.

Senator PRYOR. Mr. Smith, do you want to comment?

Mr. SMITH. Yes, only to say that the combination of legislative and administrative proposals will reduce what the costs would otherwise have been for our employees. But, there obviously is radical inflation in health care, so there still would be premium increases in 1991.

Senator PRYOR. For the Government or for both?

Mr. SMITH. For both parties.

Senator PRYOR. Would you shift the burden? Would you shift more of the burden for the premium to the employee?

Ms. NEWMAN. No.

Mr. SMITH. No. It is a combination. In part, the premiums would actually come down because of the various actions proposed, and then we would slightly increase the employee's contribution. The net effect, however, is that the employee's obligation decreases slightly from what it would otherwise be.

Senator PRYOR. Decreases slightly?

Mr. SMITH. Decreases slightly from what it would otherwise be.

Senator PRYOR. All right. So you have an $850 million package and you are going to try to save $100 million. Where does the other $750 million come from?

Ms. NEWMAN. Well, we have a combination of the administrative actions and the legislative. Under the administrative actions we have cost containment, and it is our estimate that there would be $78 million savings from that. Improving the cash management, we are expecting $40 million.

Senator PRYOR. Where is the $40 million, please?

Ms. NEWMAN. Improving the cash management of our program, using the letter of credit.

Do you want me to go on?

Senator PRYOR. I am trying to find $850 million.

Ms. NEWMAN. I am adding it up for you.

Senator PRYOR. All right. Let's go.

Ms. NEWMAN. The cost containment saves $78 million, improving the cash management saves $40 million, using the Medicare maximum allowable actual charges, $144 million. Then, under the legislative proposals, unifying the reserves would save $351 million.

Senator PRYOR. What do you mean, "unifying the reserves"? What is this?

Ms. NEWMAN. Right now, Mr. Chairman, each of the indemnity health plans has a separate contingency reserve. The target for each of those reserves has been up to 2 to 3 months claims payments, previously. We are talking about doing two things. We are talking about bringing all of the reserves together. Looking at our history we don't believe that we need to reserve any more than the equivalent of 1 month, particularly if we unify the reserves. So, in doing that, we believe, that we would come up with a savings of $351 million.

Ms. NEWMAN. Eliminating the State premium taxes would save $37 million, and then setting the Government contribution at 67 percent of the weighted average would bring about a $200 million savings, for a total of $850 million.

Senator PRYOR. Now, if you are not increasing premiums for the Federal employee and you use the weighted average system, how does the Government save money? I don't understand this. I am not linking into this.

Ms. NEWMAN. We previously computed the Government's contribution as 60 percent of the "Big Six." What we are saying is that, at the time that that formula was initiated, about 90 percent of enrollees in the program were in the "Big Six" plans. Now, it is only 30 percent. So we are saying that we should really move to using a program-wide weighted average approach. But in doing this, we are recommending that the Government's contribution be 67 percent of the weighted average. Now, this will result in about a 2 percent reduction in the Government's total contribution.

Senator PRYOR. All right. Now, let me ask this. Let me move to another track for a second. If we go to a locality pay system—and this ultimately relates to health benefits—this means that a Federal employee working in a Social Security office in New York City will get higher pay than a worker doing the same job in Arkansas. Is this correct? So, the guy in New York is going to make more money than the person in Magnolia, Arkansas, doing the same job because the cost-of-living is higher in New York.

One of the things that runs up that cost is health care. Health care costs are more in New York City than they are in Magnolia, Arkansas. Now, by the same token, is there a way when we pay the worker more in New York and the worker in Arkansas less, can you reduce the premium for health insurance in Arkansas?

Ms. NEWMAN. Well, Mr. Chairman, as you know, we are coming forward with a pay reform proposal that does recommend a locality-based pay.

Senator PRYOR. We tried this, by the way, in the health care field with hospitals using a payment system based on the patient's DRG (diagnosis related group). I must say I don't think it has worked, and I would just urge caution on this approach.

Ms. NEWMAN. On the locality-based system?

Senator PRYOR. Yes.

Ms. NEWMAN. Well, I think we will have many opportunities to talk about it.

Senator PRYOR. Yes. I am leery of it. I have been through the excruciating dilemma over the last few years in the DRG program. We find wide disparities between urban and rural areas. I also think we find a great deal of injustice in this system. So, I am just saying I want to work with you on locality pay, but I am leery of it. I have got to be convinced, and I think there are lot of members of this Committee who will have to be convinced of the locality-based pay program.

Ms. NEWMAN. Mr. Chairman, some of the important considerations for us determining locality-based pay, will be the proper determination of what represents a pay area and how to conduct surveys that are realistic surveys, and we would be talking about adding in state and local governments which we do not do today.

And, to respond to your question about the impact of health care costs if we went to that kind of system, in determining what the pay should be, we would be looking at labor costs. And, we would be asking questions as to what extent can we compete with the private sector, to what extent are we having difficulty with turnover, and what are our competitors doing—the private sector, state and local governments—in providing the full package. And, what I am suggesting is that although there won't be specific questions asked about the cost of health care, when you ask the question about labor costs and competing labor costs and analyze where you are having difficulty recruiting and retaining people, embedded in that process is a consideration of the whole compensation package.

Senator PRYOR. May I ask you a question, Mr. Smith, not that this is so hard. I just want to know about the area of cost containment. What you are sensing out there in the insurance industry with the major companies? Are they coming, let's say, to the bargaining table today a little more? Are they not being invited? Are they not attending? Are they not participating in the chain of cost containment in the insurance business? What is their attitude?

Mr. SMITH. In our business, they are certainly being invited, and their reaction I think is mixed. We deal with a lot of carriers. Some of them are very hesitant, some of them have been more willing to come forward and to try various kinds of cost containment measures.

Cost containment offers us the opportunity to do things right and make the best use of our money, and when you have a health care system where costs are escalating so rapidly it seems to me just really critical that we get better at that.

Senator Pryor. I have been through the 2-year fiasco of catastrophic Medicare, and I came our on the losing end of that deal. I have spent about 11 months as a member of the Pepper Commission, and I don't know whether we are going to be winners or losers there. It has been a very, very arduous and compelling challenge. But what I have sensed ~~out~~ there is that we may—and I underline "may"—be getting the attention of the insurance industry. However, automatically building in a figure of $78 million into the budget for cost containment concerns me: 1. I don't know how you arrived at the figure; and two, at this moment I think you may be a little optimistic. I don't see a lot of cost containment in our health care delivery system. I just don't see it.

Mr. Smith. No, and I would agree with you, although we did work from our actual experience and we looked at the plans that have done things with cost containment——

Senator Pryor. I hope you succeed, don't get me wrong.

Mr. Smith [continuing]. And averaged those savings. And what we are looking at is what we have seen happen with various cost containment measures to reduce primarily hospitalization costs, and have applied those to plans that don't now have them.

Senator Pryor. I have never made New Year's resolutions, but I made one this year. I vowed I would never get in a public forum without discussing the drug industry and the pharmaceutical manufacturers about how they are ripping the system off and how they have failed to come to the table. In addition to this, how they have escalated, skyrocketed the costs of those prescription drugs that are most necessary to the most vulnerable part of our society. From 1980 through 1938, we have had a 28 percent increase in inflation; yet, we have seen prescription drugs go up 88 percent. You see drug companies putting out huge ads saying it takes $100 million to bring a drug on the market or to do research on AIDS and cancer.

What they don't tell you is that we let them write that cost off. This is a social policy expressed in the tax code. We give them FDA approval. We give them a 7-year patent where they have no competition. They get all of this, and then they go to Puerto Rico and make the drugs there because they don't have to pay any income tax.

Now, I hope you will look at this. I will be introducing legislation in a couple of weeks that I think can save $400 million in the Medicaid program if we make these manufacturers submit themselves and compete to be on a formulary. They don't like that word, "formulary." They don't like any Federal involvement, but in the health delivery chain, they have not recognized their duty to be a part of cost containment. Seventy percent of the people in our country, elderly people, have no protection today—none whatsoever—over the rising costs of these drugs.

By the way, I have never been involved with a piece of legislation not yet introduced—no one has seen it nor have I seen it, although I know generally what is going to be in it—where there has been so much opposition to it. It is from the Pharmaceutical Manufacturers Association (PMA). So get ready for them. They are tough, they are hard, they are rich, and they are powerful. And I must say this, although I hate to say it, they are greedy. I hope that through your leverage, through our leverage in the Federal system, we can bring them to the negotiating table. They don't want to do it.

I have a lot of questions that I need to ask. We are going to have two or three votes this morning on the Senate floor. We are working on a miscellaneous tariffs bill, and I think rather than getting interrupted, I am going to try to speed the hearing along and submit the remaining questions. One of the areas that I want to raise is the structure of the proposed program. I don't think we are looking enough at what benefits those plans contain. I think we have got to concentrate more on the benefits and on the quality of these insurance proposals.

Ms. **Newman**. Mr. Chairman, may I say something about that. I am chairing a task force as part of the Domestic Policy Council. On that are representatives from Health and Human Services, Department of Defense, from OMB and the Council of Economic Advisors, and one of our charges is to look at benefit packages in the private sector, look at benefit packages in other parts of the public sector where they have been very successful, to help guide us in what it is we plug into—whatever structure we agree upon.

Senator **Pryor**. There are 15 members on the Pepper Commission. One morning last winter, as we started our meeting one of our members had a quiz for each of us. Here we were, the so-called health experts in the country. This quiz asked what our own insurance covered—dental, mental health, mammograms, you name it. We all flunked. Health insurance I know is a very complex issue. I want to work with you, and be a constructive part in forming some type of a reform package.

I have a statement from Senator Wilson that I am going to place in the record. Senator Wilson also has, in addition to his opening statement, several questions relative to your testimony this morning.

[The opening statement of Senator Wilson follows:]

Opening Statement of Senator Wilson

Mr. Chairman, I am pleased that the subcommittee has the opportunity this morning to examine problems with the Federal Employees Health Benefits Program [FEHBP] and review recommendations for reform.

It is clear to all concerned that FEHBP suffers from major structural deficiences stemming from risk segmentation and administrative inefficiencies. Once lauded for the choices it offers active and retired employees and their dependents, FEHBP participants now face the confusing challenge of selecting from among 20 fee-for-service plans and 300 HMO's and other prepaid plans.

With the proliferation of FEHBP plans, it appears the popular expression "too much of a good thing is bad for you" may very well be true. Too much choice has resulted in a program that is costly, confusing and inefficient.

The challenge to design a new health insurance program for Federal employees is a formidable one. A number of proposals have been offered, including plans outlined by Senator Stevens and Representative Ackerman and the proposal put forth by the Office of Personnel Management [OPM]. All of these plans favor a simplified program that maintains choice for participants while addressing the problems of adverse selection and economic inefficiencies.

Mr. Chairman, I recognize that some of these propsals are silent on the design details that would accompany significant FEHBP reforms. However, I do not believe it is premature to focus our attention on the benefit packages envisioned.

In particular, I am interested in the concept of optional or supplemental plans that is embodied in many of the pending FEHBP reform proposals. Such supplemental packages—available at the participant's option and without a government contribution under the OPM plan—offer access to important benefits at group rates without additional expense to the Federal Government.

As you well know, Mr. Chairman, I have a long-standing interest in long-term care insurance and believe that the Federal Government should take the lead in offering this important benefit to its employees. My legislation, S. 38, creates long-term care as a new optional benefit for Federal employees and gives those with ten years experience in FEGLI the option of diverting a portion of their life insurance to long-term care coverage.

As the Pepper Commission noted in its March report, the private sector long-term care insurance market must play a substantial role in meeting the growing demand for long-term care. FEHBP reform provides the Federal Government with the opportunity to facilitate the development of the long-term care insurance market by including a group long-term care benefit in a FEHBP supplemental plans or plans.

By offering long-term care to such a large pool of workers, the Federal Government can offer participants an important new benefit, provide a significant incentive for insurance carriers to improve the quality and affordability of their long-term care products, set an example for private sector employers, and help to establish the actuarial date lacking in the long-term care insurance arena.

Mr. Chairman, I believe the time is right to offer a long-term care benefit to Federal employees in the context of FEHBP reform. I look forward to working with you and the committee, OPM and others to design a meaningful reform of the FEHBP program.

Senator PRYOR. Before we conclude I must say that the "call letter" has given us some concern. I would like to know about the Government's contribution for the period of January 1 to September 30, 1992.

Ms. NEWMAN. Mr. Chairman, there was no change. It was not our intent to change. As a matter of fact, the main reason that we did this was in trying to put together our proposal and in discussions about the costing of it, we had a great deal of difficulty because we were operating on a calendar year as opposed to a fiscal year. We had absolutely no intent to change the agreed upon formula. This is more administrative.

We also think having open season around Christmas hasn't been too helpful. I know that you are concerned about it being in August. We thought that would be an easier time.

Senator PRYOR. Is August the time when most people take vacations or not? I don't know.

Ms. NEWMAN. I saw a lot of people around this year.

Senator PRYOR. Let me ask about phantom formulas. How are you going to get along with phantom formulas?

Ms. NEWMAN. Well, in our proposal, you know, we are talking about self-insurance, so that if we do go to self-insurance we would not be concerned about that. But as far as the present, during the transition we are talking about continuing what we had agreed upon this last session, session before last.

Senator PRYOR. Will there be an open season in 1991?

Ms. NEWMAN. Yes, there will be an open season every year.

Senator PRYOR. I want to thank you, Ms. Newman and Mr. Smith. Once again, we will be submitting some questions in writing for the record. I think several of my colleagues will also want to submit questions.

We very much appreciate your coming. We know you have a big task ahead and we look forward to working with you.

We will call our next panel. Dennis Snook, Janet Lundy, Michael O'Grady, Sheila Smythe, Alan Fairbank. This fine group represents the Federal Employees Health Benefits Team from the Congressional Research Service. CRS with all of its knowledge, resources and wisdom is now ready. Who will be the spokesman? I think that you have about a 15- or 20-minute segment here. Dr. Snook, we look forward to hearing from you.

TESTIMONY OF DENNIS SNOOK, Ph.D., FEDERAL EMPLOYEES HEALTH BENEFITS TEAM, THE CONGRESSIONAL RESEARCH SERVICE

Dr. SNOOK. Thank you, Mr. Chairman. The FEHB team is a cooperative effort of the Congressional support agencies. Unfortunately, Ms. Smythe, our consultant from GAO, was unable to be here this morning.

Good morning Mr. Chairman and members of the Committee. The Federal Employees Health Benefits Team[1] appreciates the opportunity to address the Committee on the subject of Federal employees health insurance. I am Dennis Snook, and with me today are members of the team, which was created to serve certain technical interests of the committees as they review the Federal employees health program. To my right are Janet Lundy and Michael O'Grady of the CRS, to my left is Alan Fairbank of the Congressional Budget Office.

Mr. Chairman, the FEHB team thoroughly studied the health benefits program and we developed a methodology that allows us to compare the multitude of plans and programs to each other, to plans in the private sector, and to the approaches that might be used to reform the program. Details of that study can be found in our report published by the Post Office and Civil Service Committee last May. I will briefly summarize our study findings, and other panelists will elaborate on specific areas.

The FEHBP will spend $12.5 billion paying for the benefits of over 9 million employees, annuitants and dependents during the fiscal year 1990. The Federal Government will pay about $8.9 billion, or about 71 percent of this cost. The enrollees will pay the remaining 29 percent of the cost, an amount that averages about $906 per year per enrollee.

Our study determined that the typical Federal worker receives about $1,100 a year less in employer-paid health benefits than the typical private sector corporate counterpart. That is after considering all the differences in the demographics of our populations and the differences in the benefits that are received both by our typical Federal worker and by the typical employees in the private sector.

Senator PRYOR. Do all the panelists agree on this conclusion?

Dr. SNOOK. Yes.

Senator PRYOR. No dispute?

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[1] See p. 82 for the prepared statement of the Federal Employees Health Benefits team.

Dr. **Snook**. No, there is no dispute.

After accounting for those demographic differences, we also found that the Federal population is no more expensive to insure than the general public. During the annual open season enrollees will choose from among nearly 400 plans with each individual able to select from as many as 36. This is an imperfect market. With the possible exception of health maintenance organizations, the plans are not substantially at risk for the total cost of the benefits they offer, as gains and losses of the previous year are rolled over into subsequent premiums. Nor are plans rewarded for an especially efficient operation—profits and reimbursements for administrative expenses are strictly controlled.

Most critical examinations of the program usually focus on the problems created by the existence of choice. The Government, unlike other large employers, does not choose the level of coverage it wishes to provide and then select the most efficient form for providing that coverage. Instead, individuals choose from a selection of plans that are relatively free to design benefits to appeal to them. The result is that rational benefit design becomes complicated by the marketing strategy each adopts.

This structure has led to three general problems. First, the annual multiple choice among many plans is confusing because an adequately informed selection is nearly possible to achieve. Second, the spread of benefits across the array of plans has caused a distribution of the burdens and benefits of the program that contradicts both the ordinary expression of an insurance principle and the presumption that a program of public policy will provide similar treatment to individuals in similar circumstances.

And third, this spread has created a dissipation of a potential market force of more than 9 million people, and it dilutes the strength that could be harnessed to reduce Federal obligations for the program and, perhaps, to lead efforts to gain control of overall health care costs.

In short, the program is a complex dynamic between plans and participants. The primary purpose of the program—financial protection against medical costs—is confused, and its goal—avoiding unnecessary Federal expenditures—is uncertain. The people who do the best under the program are often either lucky or they know the most about its dynamics. Those who are least advantaged are often the poorest, the oldest and the sickest.

The general issue confronting those interested in FEHB reform comes down to this: Does this array of choices work to the advantage of the enrollees, or are the actual benefit differences much less important than the demographic characteristics of the enrolled population? Does the competition for enrollees help to constrain costs, or does it make cost controls more difficult to implement? Would the Federal Government, including its employees, be better served if control of the program were more centralized so that the relationship between benefits, enrollee payments and Federal costs were a function of Federal policy rather than the residue of the participants' own actions?

Mr. Chairman, before I turn to the other members of the panel I would like to cite our general conclusion. Reform of the program can solve many of the serious problems. However, reform will not save the Government substantial sums unless it is coupled with benefit reductions, more cost shifting to enrollees, or greater control over providers.

With your permission, Mr. Chairman, other panelists will elaborate on certain of our findings, and we have included a copy for the record.

Senator **PRYOR**. Fine. Thank you very much, Dr. Snook.

Let me at this stage have the record show that Senator Stevens has joined us. Senator Stevens has attended the funeral of our colleague, Senator Matsunaga. He has flown probably 30 hours. He is here. I don't know how he is walking around because of jet lag, but let me ask if Senator Stevens would like to make an opening statement, or has a question for Dr. Snook or the panel. We will come back to their statements in a moment.

Senator **STEVENS**. Thank you very much, Mr. Chairman. I regret I wasn't here when Ms. Newman presented her position, but you correctly stated it. I live in that condition however. One time President Ford visited my State and said that the only complaint that his administration had was they found when they tried to talk to me I was hungry at midnight and sexy at noon. [Laughter.]

Senator **PRYOR**. We are going to call on Senator Stevens in a moment. He may be thinking he is making a dinner speech tonight or something. [Laughter.]

Well, let's see if we can all get ourselves under control again. Ms. Lundy, let's hear from you at this time.

TESTIMONY OF JANET LUNDY, FEDERAL EMPLOYEES HEALTH BENEFITS TEAM, THE CONGRESSIONAL RESEARCH SERVICE

Ms. **LUNDY**. Good morning. My name is Janet Lundy and I will address several cost containment issues.

As health care costs have risen, employers have sought to restrain this growth. While experience from the private sector suggests that cost controls do save some money, considerable doubt exists that they can reduce costs substantially.

Controlling health plan costs generally requires changing the following: Reducing the amount of services used by enrollees, controlling payments to the providers of services, or increasing the enrollee's share of total plan costs. And let me elaborate for a minute on these three approaches.

Many employers believe that costs can be reduced by controlling utilization. Utilization controls, also known as managed care, include such measures as preadmission certification for elective hospital stays or review of the length of hospital stay. FEHBP's HMOs use the managed care techniques adopted by most HMOs. Although not required by OPM, some FEHBP fee-for-service plans also have incorporated utilization controls. But cost-saving approaches are not used throughout the program because some plans think that adopting them will drive off enrollees because they will limit their choice of providers and their providers' choices of options for them.

We understand that OPM's instructions for the 1991 program require participating plans to include certain cost containment techniques. If such techniques are mandatory for all plans, then no plan should be at a competitive disadvantage for using them.

There are a number of ways to control costs by controlling payments to providers. However, unless providers are required or agree to accept the plan's payment as the full payment, these methods will merely shift costs to enrollees. One approach is to establish fixed payment amounts, as does Medicare's prospective hospital payment system. Another is to set maximums on payments to health care providers, such as the "reasonable and customary" limits that are used by all the FEHBP fee-for-service plans. Although these limits may reduce plan costs, lack of information about the limits makes it difficult for enrollees to compare plan payments and to understand the out-of-pocket costs that they face as a result of these limits.

Another payment approach has been to negotiate payments with providers. The Federal Government has been criticized for not using its large purchasing power to negotiate discounts for the FEHBP program. On a smaller scale, certain individual FEHBP plans are negotiating provider discounts through preferred provider programs. In addition, 2 of the 20 fee-for-service plans have prescription drug card programs where payments have been negotiated with participating pharmacies, and 14 plans have mail order prescription drug programs through which long-term supplies of drugs can be purchased at discounted prices.

Enrollee cost-sharing provisions, such as deductibles and coinsurance, are used by all of the FEHBP fee-for-service plans. Many think that enrollee cost sharing is effective in helping to control utilization, though others question whether cost sharing deters necessary utilization, and also question whether a health plan's savings should be achieved by shifting costs to the enrollees.

A question that is frequently asked is would reform of the FEHBP structure save money. As was mentioned earlier, our study found that—well actually it hasn't been mentioned yet—our study has found that one of the program's major features, choice, has an insignificant impact on overall program costs.

As we indicated in our report, and Dennis Snook just mentioned, major structural change to the program could solve certain perceived problems but would not save Federal funds unless it were coupled with benefit reductions or less freedom of choice for the enrollees, controls on providers, or more cost shifting to participants. Thank you.

Senator PRYOR. Thank you very much, Ms. Lundy. Let's call on Michael O'Grady.

TESTIMONY OF MICHAEL O'GRADY, Ph.D., FEDERAL EMPLOYEES HEALTH BENEFITS TEAM, THE CONGRESSIONAL RESEARCH SERVICE

Dr. O'GRADY. Good morning, Mr. Chairman, Senator Stevens. My names is Michael O'Grady. Today I will discuss the effect choice has on the FEHBP in terms of cost to the overall system and premiums to the enrollees. A common complaint is that choice has made the current system more expensive than it need be. As Dr. Snook has pointed out, some market advantage may be lost by not taking full advantage of the purchasing power of 9 million people, but has choice itself increased cost? The answer is no.

In general, any program allowing people to choose between high and low option plans can lead to risk segmentation, which is a grouping of healthier people in some plans and sicker people in other plans. This risk segmentation in turn can cause some premiums to rise dramatically, but it does so without increasing overall costs. The following example illustrates this point.

In this example the high option has 10 enrollees each with annual health care costs of $2,500, and another 10 enrollees each with costs of $1,500 in the first year. Excluding administrative and additional costs, the high option would result in an average premium of $2,000 for each enrollee and a total cost of $40,000. By contrast, the low option has 10 enrollees each with costs of $1,500 and another 10 with costs of $500, resulting in an average premium of $1,000 and a total cost of $20,000. Total cost for both options is $60,000.

If in the second year, five of the people with $1,500 in annual costs recognized the benefit from moving from the high to the low option, the average premium in the high option will increase from $2,000 to $2,167, and the high option cost would drop from $40,000 to $32,500. At the same time, premiums in the low option would also rise from $1,000 to $1,100, and total costs will rise from $20,000 to $27,500.

As the table shows,[1] the movement of a small number of people from high option to low option causes the premiums in both options to rise, but that the total cost of the system remains at $60,000.

So far we have examined the effect of choice on health plans in general. Now what effect does choice and the resulting risk segmentation specifically have on the Federal plan? It has caused wide variations in premiums among the different plans, with a vast majority of the price difference being absorbed by the enrollees. The following chart illustrates[2] this point by displaying the differences among fee-for-service plans under FEHBP in 1989. Three different distributions are shown here. First, the difference in the value of benefits being offered; second, the difference in premiums charged; and third, the difference in what enrollees actually have to pay.

While there are differences in the benefits offered by different plans, CRS estimates that the most generous benefit package has a value that is about 46 percent greater than the least generous package. The premiums vary much more. The most expensive plan is 246 percent more expensive than the least expensive plan. Why is there such a difference in price compared with benefits offered? Risk segmentation. FEHBP is an extreme example of risk segmentation. Premiums differ widely among plans, not because of differences in health benefits offered but because of differences in the populations being served.

The concentration of very sick people in certain plans has driven up their premiums, up much faster than rates in other plans. Conversely, other plans that have been able to attract a younger, healthier population have been able to keep their premiums down.

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[1] See p. 85.

[2] See p. 87.

This situation becomes even more extreme when the enrollees' premiums are examined. Due to the nature of the "Big Six" funding formula, which limits the Government's share of any premium, the Government does suffer some increased cost due to risk segmentation, but the brunt of these costs and gains has been borne by the enrollees. The chart also displays the range of differences in what enrollees pay. In 1989, a non-postal enrollee would pay from $240 to $2,200 annually, or a difference of about 800 percent between the highest and lowest plans.

While there is limited variation in the benefits offered under FEHBP, there is wide variation in what different workers and retirees have to pay for health benefits. Any action to change this situation should be tempered with the knowledge that without even more Government money or substantially tighter controls on cost, any attempt to reduce the high-end enrollee premiums will mean increased premiums for those currently at the low end.

Thank you.

Senator PRYOR. Dr. O'Grady, thank you very much.

Mr. Fairbank, are you with the CBO?

TESTIMONY OF ALAN FAIRBANK, FEDERAL EMPLOYEES HEALTH BENEFITS TEAM, THE CONGRESSIONAL RESEARCH SERVICE

Mr. FAIRBANK. I am Alan Fairbank with the Congressional Budget Office, and a member of the Congressional Research Service team. I do not have a prepared statement. Instead, I have a table, which you have in front of you.[1]

Senator PRYOR. Yes, I am looking at it. Thank you.

Mr. FAIRBANK. This morning I would like to make some general comments about the President's budgetary proposals for the Federal Employees Health Benefits Program (FEHBP), and particularly, to focus on the proposals for a weighted average and their budgetary impact.

I would like to suggest that there are, as Janet Lundy has suggested, limited ways to save money in the FEHB program. First, you could reduce benefits; second, you could transfer Government costs to other parties; and third, you could constrain utilization or provider payments. Some might argue that the third category is just a subset of the first two, with minor savings to be achieved in that third category.

The President's budget does not propose to alter FEHB benefits. Therefore, the total costs are likely to be just about what they would be under the baseline. The President's budget does propose, however, significant outlay reductions by transferring Government costs to others. The first proposal would shift liability for the payment of annuitant health premiums from the Government to the Postal Service and to the District of Columbia. This hasn't been mentioned this morning, but it is in the President's budget and it would save about $726 million in fiscal year 1991.

A second proposal in the President's budget would shift costs from the Government to non-postal employees and annuitants by changing the method for calculating the maximum Government contribution toward FEHB premiums. There are other proposals that were mentioned by the OPM director which seek savings through administrative actions, cost containment, the unified reserve, and such—some of which would require legislation. I don't have sufficient detail on those to comment on their budgetary impact. Instead, I would like to focus on the weighted average proposals.

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[1] See p. 204.

As Ms. Lundy pointed out, there are basically two proposals. Alternative one is to change from the simple average of the "Big Six" carrier premiums to an enrollment-weighted average and to maintain the percentage of 60 percent. OPM contends that this would save $850 million in 1991. The second alternative proposed would use the enrollment-weighted average and raise the percentage to 67 percent.

Before I get into the table, let me give a little background on current law. Current law establishes the amount that the Government will pay by establishing two elements. First, a formula establishes the maximum dollar amount that the Government will pay. Second, the law requires employees to pay a minimum percentage of whatever premium they choose. This minimum is 25 percent. To put it another way, it limits the Government contribution to 75 percent of whatever premium the plan has, whichever is lower.

The formula for setting the maximum dollar amount has two components. The first defines how to establish the average premium; the second specifies a percentage of that average. The product of the two gives you the maximum dollar amount. Under current law, the definition of average is the simple average of the total premiums for the "Big Six plans." If you turn to the table, you will notice these averages in the first column. The first row shows that the average total premium under the "Big Six" formula is $4,318 for self and family coverage. The three rows underneath show that this would be $3,523 under the enrollment-weighted average, quite a bit lower. The second column shows the percentage that, when multiplied by that first column, gives you the maximum dollar amount.

The third, fourth, and fifth column, in effect, shows how much of the total premiums are paid for by the Government for employees, for annuitants, and for both groups combined. Under current law and with the percentage fixed at 60 percent of the "Big Six" formula, the Government pays 67 percent of the total premiums.

Now, this 67 percent, as the OPM director pointed out, has risen in recent years. In 1983, it was only 58 percent using the same formula. Since then, it has risen to 67 percent. This gradual rise is one of the reasons behind this impetus to move to the enrollment-weighted average.

If you look at the two alternatives, you will see OPM's alternative number one—the enrollment-weighted average, but keeping the 60 percent—reduces the share the Government pays for total payments to 59 percent and saves, according to my calculations, $800 million in fiscal year 1991. OPM, alternative number two, instead of keeping the 60 percent, raises it to 67 percent. I agree with OPM that this would result in an aggregate payment of 65 percent of total premiums. My calculation is that this would save $275 million in fiscal year 1991.

The last line of the table is inserted to make an important point about the enrollment-weighted average. To date, when we hear the words "enrollment-weighted average," we think of budget reduction proposals. In fact, the element of the budget reduction in these proposals is not necessarily the enrollment-weighted average, but rather the percentage by which the average is multiplied that reduces the maximum dollar amount. It is possible, as this last line points out, to use an enrollment-weighted average and fix the percentage so that the maximum dollar amount is equal to what it would otherwise have been under the old formula or under current law.

According to my calculations, that budget-neutral percentage would be about 72 percent. If the "Big Six" formula were considered to lead to increasing shares in future years because of its unrepresentative nature, the enrollment-weighted average would tend to make the Government's share more stable and more predictable.

Finally, I would like to comment on the effect of these two proposals on employees. To the extent that the Government pays less, according to these proposals, enrollees—that is, Federal non-postal employees and annuitants—would have to pay more and, in each case, substantially more. The $800 million figure translates into about an 11 percent reduction in the Government payment costs. That increase does not count, of course, any increase in costs of health care which would translate into an average of about a 22 percent increase in premiums for employees. OPM's alternative number two would be about a 4 percent decrease for the Government, which would translate into about an 8 percent increase for employees. Both estimates are independent of what we expect to be a 12 to 13 percent increase in the premiums, on the average, in fiscal year 1991.

If you put those two increases together, alternative number one might conceivably raise average premiums for employees in the neighborhood of about 35 percent; alternative number two would put it in the range of around 20 percent. Of course, employees have the choice to switch to lower cost plans that could reduce their costs, but these percentage increases would apply for the same plan.

Senator **Pryor**. Thank you, Mr. Fairbank. Senator Stevens.

Senator **Stevens**. Well, that last part is a little confusing to me, I am going to have to study that, but I don't quite understand if you increase the Government's percentage to 72 percent how you increase automatically the employee's contribution.

Mr. **Fairbank**. The question was?

Senator **Stevens**. Your chart shows that if you increase the percentage for fixing the Government maximum to 72 percent, which is the same as current law, you automatically increase the employee contributions.

Mr. **Fairbank**. No. In the last line, neither the Government share nor the employee share of the contribution changes. As you see in the fifth column, 67 percent of total premiums would continue to be paid by the Government and 33 percent by——

Senator **Stevens**. But the average for the premium is approximately $1,000 less. Now, you tell me how that works out.

Mr. **Fairbank**. The maximum dollar amount is derived by multiplying column 1 by column 2. In other words, 60 percent of $4,318 is approximately the same as 72 percent of $3,523.

Senator **Stevens**. All right. I don't know if this is your conclusion, or whose conclusion this is, Mr. Snook, but Federal payments for health insurance for average Federal employees is approximately $1,100 per year less than employer payments for health insurance of a typical private sector corporate counterpart. Whose conclusion is that?

Dr. **Snook**. It is a conclusion of the FEHB team.

Senator **Stevens**. Does that take into account the deductibility for the employer if it is a private employer, or the possibility for payment of employee health costs out of pre-tax dollars?

Dr. **Snook**. It is one of the more complicated comparisons we made. It takes into consideration the possibility that the private sector employee will qualify for retiree health benefits. It takes into consideration the possibility that those retiree health benefits will be less valuable than those available under the Federal program. It amortizes the cost of those retiree health benefits over a lifetime of work, and the tax effects, because to some extent taxes deferred are taxes paid at a later date.

Senator **Stevens**. That is the employee's side you are talking about now. I am talking about the employer comparison, the cost to the employer you say is $1,100 more for the private employer than for the Federal employer.

Dr. **Snook**. The private employer is able to deduct the cost of health insurance as a business expense, and he would be able to deduct the cost of that same health plan if he paid its cost to the employee as salary and the employee paid for the plan directly. It is correct, as I think you are suggesting, that there would be a difference if the employer had a flexible spending account that allowed the employee to make his payments out of pre-tax dollars.

Now, when we did the study there were a number of private sector plans that had flexible spending accounts and did permit employees to pay their copayments, deductibles and premiums out of pre-tax dollars. And at that time there were substantially fewer of them than there are now. So we did include some of that, but it would make, I think, that number somewhat higher today as a result of the broader number of employees in the private sector having such an opportunity.

Senator **Stevens**. Mr. Fairbank, I am not certain I understood the last comment you made, which indicated that the cost would ill be higher. Can you repeat that last comment you made?

Fairbank. The point I was trying to make regarding the
eutral option was that the most important factor in dictat-
ch the Government contributes is the maximum dollar
figure is derived by multiplying an average times a
change the definition of the average, which is
sed here, to an enrollment-weighted average,
maximum dollar amount just by changing

So when they go from the "Big Six" average to the enrollment-weighted average, which is much lower, and keep the 60 percent, their savings come because they are really lowering the maximum dollar amount by quite a bit. But if you go to the enrollment-weighted average and then adjust the percentage upward to 72 percent, you come up with the same maximum dollar amount, which has no budget impact for either the Government or the employees.

Dr. **Snook**. One way to understand that, I think, is that right now it requires a computation for analysts to determine what the average Government share is, and the results of our computations—both ours and OPM's—is that the average Government share is now 67 percent. You could fix in law that the average should remain at 67 percent, or 72 percent of the average premium. At that point the result would be the same. One would have been the result of computing the effects of current law. The other would be making as current law the effects that are already occurring.

Senator **Stevens**. But that would leave with the providers the determination annually of the amount that the Government was going to contribute, would it not?

Dr. **O'Grady**. Over quite a number of them. I mean the insurance company that had the greatest influence would be that with the largest market share. When you go to a weighted average it is, in effect, simply how costs have gone up over the entire system, and OPM has made a fairly reasonable argument that because the plans that make up the "Big Six" have gone up faster than the rest of the system, rather than the old 60/40 split between the Government and employees, the split has crept up now to more like 67/33. When we take into account the postal system, it is more like 70/30.

So they have made what we think is a reasonable argument. Why not have the Government's share go up at the same rate as the whole system has, and that is a reasonable point. Now, if you link that with rolling back to a 60/40 split between the Government and employees, you are going to have a substantial shift of the cost of this system on to the employees.

And what Alan is saying is you don't have to do those both at the same time. You could go to a weighted average, without changing the Government's share of the costs—if the total system goes up by 13 percent, the Government's part of that would go up by 13 percent. The Government doesn't continue to be disadvantaged by the "Big Six," but the employees don't suddenly get a big shifting onto them of the burden of this program.

Senator **Stevens**. Well, when Aetna pulled out we created the myth that the "Big Six" was were still there, and we did it for the purpose of trying to maintain a level playing field. But what we really did was we tilted it so that as the cost went up the Government took more of the increase in the share of cost to the employee, isn't that true?

Dr. **O'Grady**. As costs would have gone up——

Senator **Stevens**. They did go up.

Dr. **O'Grady**. Yes. Well, certainly. I mean, certainly nobody should kid themselves that no matter what we do costs are going to go up.

Senator STEVENS. Well, didn't the myth tilt the increase so that the Government paid more of the increase than the employee?

Dr. SNOOK. To the extent that that occurred, Senator, that was a result of the difference between projecting in advance what would be the likely phantom of the——

Senator STEVENS. Well, what would have been the result if we didn't create the myth, if we had gone to the average of the five providers instead of the six?

Dr. SNOOK. I don't know that we have done that analysis. We did it beforehand to examine what would be the effect. I am sure OPM counterparts have.

Senator STEVENS. Well, I would like to know what would have been the result as far as the employer and employee if we had not created this myth.

Dr. O'GRADY. It would have shifted more. I think it is pretty safe to say, without giving an exact figure, that given that Aetna was suffering some fairly high increases, that if you took out one of the higher—I mean, the idea here in the "Big Six" is that not all of the six have suffered the kind of risk segmentation. Some of them have done very well under risk segmentation, but the high option plans of Blue Cross and Aetna were getting beaten up badly. And if suddenly Aetna was pulled out of that you just went to a "Big Five," it is a pretty safe bet that you would have seen shifting onto the employees.

Senator STEVENS. That is what we thought. At least I think that was our rationale, that there would have been an enormous shift to the employee, and so we should keep a level playing field, and we thought that it would keep the increases balanced between the employer and the employee caused by the withdrawal of the 6th provider.

Now, I would like to see whether our assumption, based on what happened since then, was right or wrong. I think it would be indicative of what might result if we make some similar assumption in the future. Just for the record I would like to see it.

Second, I want to thank all of you for the work you have done with me and my staff on looking at the cafeteria plan. In any of these analyses have you taken into account the decreased cost to the employee if we in fact use the before-tax fund approach to pay for just the existing system without regard to cafeteria plan? If we allowed the employees to use the before-tax concept, what would be the impact on the employee cost?

Dr. O'GRADY. We know certainly that that would be an advantage to the employees. The hard part of coming up with a firm estimate on that is that we cannot simulate the tax return of the Federal employee very well.

Senator STEVENS. Well, you can simulate what is happening out in the private sector.

Dr. O'GRADY. Certainly we can take a look at that and we could make some analogies and the bottom line is that if you allow people to pay things pre-tax rather than post-tax, sure that is going to be an advantage to them.

Senator STEVENS. Mr. Chairman, I still remain convinced that the reason that our costs are going up is that we are not changing, as the private sector is, in terms of some of the options that are available in the private sector to prevent the duplication of benefits to those couples who are both working. And I think we have the same percentage of people in the Federal Government who have two incomes per family as exist outside of the Government.

That is another assumption I would like to have you tell me if I am right or wrong. But in any event, there is an increasing utilization in the private sector of the before-tax payment for benefits such as health insurance. We have not extended that same prerogative to Federal employees generally, although I understand there is a small section of the Federal Government that does have that available, and it would be nice to compare those against the overall employer.

It seems to me that one of the factors in this cost to the employer is the payment that is being made by the employer for health care services for employees who also have payments being made either by the Federal Government or another employer for the same services for the same family. There is a duplication of cost to employers, and yet by definition both of the health care carriers are not paying for the same illness. As a consequence, there is, in the Federal system, a waste as far as both the employer and employees are concerned that ought to be eliminated, and the tax code gave an opportunity in the private sector for that to be eliminated through a choice system and more and more of the private sector is going to the cafeteria plan, I think, to give the employees that choice to have increased benefits at the same cost to the employer or at no additional cost to the employer.

I would like to pursue that, but I am reluctant to do so, however, until we can get some general understanding of what would be the increased cost and how important would be the increased benefits to the Federal employee sector.

I think that the assumption we are all making is that it has got to be budget neutral. I am pleased to see that the bottom line, which would indicate really, as I take it, is we could have a budget neutral concept develop which would really not change the current Federal contribution and at the same time really not increase the employee contribution significantly. If that was so, and we also used the cafeteria plan, then I think we could increase benefits without increasing costs to either the Government or the employee.

Dr. SNOOK. We will be happy to continue working with your staff in the development of any proposal that you are interested in.

Senator STEVENS. Thank you very much. Thank you, Mr. Chairman.

Senator PRYOR. Thank you, Senator Stevens.

Mr. Fairbank, we are going to place your chart in the record, and I am sure that chart and other information that you have supplied the Committee will be most helpful.

In fact, the person who needs the most help in this area is the Senator from Arkansas. I am totally confused right now. I think we have a major dispute in basically the conclusions offered by the OPM Director, Ms. Newman, and your findings. Am I wrong? You are disputing her figures; is this correct?

Mr. FAIRBANK. Well, I am not sure if she understood the question correctly. I think the way she responded was to talk about total premiums. I imagine that she would agree that employees are going to pay more under both of these proposals. I mean, there is just no question about it.

Senator **Pryor**. Here is my confusion. My confusion is based upon the assumption that we can have an $850 million savings, knowing that health costs and premiums are skyrocketing. Furthermore, the Federal employee is going to be paying less, while benefits are going to be the same or better.

Dr. **Snook**. I think your intuition is correct. [Laughter.]

Senator **Pryor**. I don't know whether Mr. Darman has taken everybody to school around here and taught them all of this, but I can't fathom all of this happening.

Dr. **Snook**. I think that one of the things that is always important to keep in mind in talking about health insurance in general is that the phenomenon driving the cost is something that occurs independent to the existence of the way in which it is scored, and that is demands for services by sick people. If you do not change the extent to which their benefits are covered and you lower the Government's cost, then you inevitably will either increase the cost to the employees or somehow find a way to reduce the amounts that are going to be received by the providers who are providing the services. There simply is no other way.

Senator **Pryor**. I don't see another way. I may be wrong. I thought I had missed out on something here.

Dr. **Snook**. I think the logic is impeccable.

Senator **Pryor**. All right. Well, I feel a little better. I thought I was the one who had jet lag around here.

I want to thank this panel. Once again, we are anticipating some votes fairly soon and we have further questions for the panel that we will submit in writing. For example, what is going to happen if the Postal Service sets up a separate plan? I am very interested in this.

I am also interested in Senator Stevens' pre-tax dollars concept. I really have not followed that closely. I believe it was last August when Senator Stevens unveiled this concept, either in a bill or in a speech on the Senate floor. I would like to closely look at that concept also.

Senator **Stevens**. Mr. Chairman, if I could interrupt you, if I ever get to the point where we have got a concept I want to share it with you, but currently we are still looking at numbers and they won't fit together yet. So I don't think we have a bill yet, and we don't have really a comprehensive proposal that could be discussed with anyone. I think that the concept we are pursuing ought to be workable, because it is certainly workable in the private sector, but we haven't been able to fit these numbers together under existing law, and we haven't been certain yet how we have to change existing law to be able to put the numbers together. So there is still a dilemma, I can tell you. I hope to work with you and would like to do so.

Senator **Pryor**. Yes, and let we commit my efforts, whatever they might be, to work with you, Senator Stevens.

Let me also make note that Ms. Newman is still in our audience this morning. I wanted her to know that in no way were my remarks intended to reflect badly on her intentions, but I do sense a dispute here. Eventually, we will have to go back to the drawing table to try to iron this out.

Once again, thank you for your participation. It has been very enlightening, and I must say, very stimulating. Thank you.

We will next call Mr. Harry Cain, II, Senior Vice President, Federal Programs, Blue Cross and Blue Shield.

Mr. Cain, we appreciate your being here this morning and look forward to your statement.

TESTIMONY OF HARRY P. CAIN II, SENIOR VICE PRESIDENT, FEDERAL PROGRAMS, BLUE CROSS AND BLUE SHIELD [1]

Mr. CAIN. Thank you very much. I would say at the outset that to the extent there was a dispute between the OPM and the CRS panel comments on those questions, we would have to side with the CRS. We have some concerns about what is in the President's proposal, and perhaps after I say a few things we can come back to that.

You have our prepared statement, and if you will accept it for the record, I will simply briefly summarize our point of view.

Clearly, as the two previous commentators, or sets of commentators, have suggested, this is a very complex subject, but I think it can in some senses be seen in fairly straightforward terms. From our point of view, the Government's health and benefits program should have four objectives or four consistent characteristics: one, it should provide good coverage for all who want it; two, it should offer good service for all who want it; three, it should have a reasonable cost for all concerned; and four, it should include choice, choice in the sense that if an employee or a retiree does not like the coverage or the service or the cost of the plan he or she is in, he or she can change to some other. That one element of choice among competing plans is, in our view, the best way to assure a program that is responsive to its clientele.

Throughout almost all of the FEHBP history all four criteria have been satisfied with one glaring exception—the costs have fallen very harshly on some consumers and fallen very easily on others. While the cost of the entire program, as the CRS report shows, hasn't increased excessively, in fact hasn't increased as fast as other private sector employers' health programs have, the costs haven't fallen equally or evenly on all the participants. Subscriber costs have fallen most heavily on the oldest and the sickest and those most unable to switch plans.

The underlying dynamic which has caused that to happen has been the increasingly uneven spread of risk among the various plans, and as more and more carriers and HMOs have entered the program, that problem has become more and more severe.

Fortunately, the increasing segmentation of risks and its causes and consequences are now more widely understood than they ever were before, and I think that is really thanks to the TPF&C and the CRS reports. The one issue, it seems to us, before you, the central issue, is how do you solve that problem, especially how can you solve it and still maintain the features of the program that have been both attractive and successful for 30 years.

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[1] See p. 95 for Mr. Cain's prepared statement.

You have heard or seen OPM's proposal. OPM would essentially scrap the current program, except for a few hundred HMOs, and turn it into something like Medicare. Medicare is a program we know quite a bit about, and we believe strongly that an FEHBP that was constructed like Medicare, or CHAMPUS, for that matter, would be much less responsive and more hazardous than the current program has been. Our prepared testimony spells that out a little further with some examples.

From our point of view, the interesting issue is why are the OPM and OMB pushing for the kind of self-insurance program, as conveyed in their proposal, and have the Federal Government take on the full risk? It is particularly interesting because the major reasons that private employers choose a self-insured program simply do not apply here. They are not applicable. I would observe as an aside that in the private sector we often advise major employers to self-insure. It is a very smart thing to do. In the Federal Government we have the opposite point of view.

We think if you look closely at the history of the health programs of the Federal Government, which are self-insured and have been self-insured for a long time, you will see a record which won't inspire confidence.

Senator PRYOR. Mr. Cain, I think we are going to have a vote momentarily. Let me suggest that if you are finished with your summary, we open up for a few questions and place the full text of your statement in the record. Do you have a further point or two you would like to make?

Mr. CAIN. I have several other points, but I believe I have already said the essence of what our point of view would be and I can provide for the——

Senator PRYOR. Well, you have said enough at least to convince me that you are not in the category of undecided.

Mr. CAIN. Right.

Senator PRYOR. Senator Stevens, would you have questions of Mr. Cain?

Senator STEVENS. Mr. Chairman, I apologize, I am going to have to leave soon. I came in late, but I still have to leave.

You indicate, and I did read your statement too, that the designers of the FEHBP and the industry both made the assumption that most of the population of the Government employees would choose the low option in Governmentwide plans, not the high option: Congress did too, and we were all wrong.

Having been wrong, however, you now say that it is wrong to base a plan on the opposite assumption, and that we would be better off if we had a basic self-insurance approach.

It appears to me that what we have to do is sort of, as the oral statement said, disenthrall ourselves of the past and try to find out what is going to be best for the future, and we are going to have to make some new assumptions.

Have you in the industry that you represent looked at the problem of the approach we have used in the past of assuming that there should be some employee choice in the basic services that are available, and instead having an approach which says that, in particular, the costs of general services that have been demanded by the employees will be assumed by the Government, and anything in addition to those will be insured by the employee?

Do you understand what I mean? There is, in the employee population, a whole series of demands that are made for health coverage by most employees. They are the routine things that come in that you have paid for and they are the basic costs to the insurer and to the employer. I would think that what we ought to look at is a plan which said not high and low option, but a plan which says the Government is going to pay for these costs which are the normal costs incurred by all employees, and if you want to insure against additional costs, here is the cost to you and the cost to the Government to insure against those. What do you think about that?

Mr. CAIN. I am not sure I understand, Senator, how it would work. I take it you are talking about a flexible benefit, cafeteria style program.

Senator STEVENS. Yes, in effect that is right, but what I am saying is there is a whole series of things out there, from pregnancy to tonsils, and all of the things that would come into a normal health bill that families face, whether they are Government employees or not, and I would say the employers ought to pay those, just the normal costs. There are additional costs that come in that are the unique health costs, and I think that those have to be insured against and both the employer and employee ought to share those additional costs.

So that if you assume a low option—let's just assume that the low option should have been the thing the employees took, and let's have the employer pay for the low option. The difference between the low and high option costs would be insured against by both the employer and employee contributing. What do you think of that?

Mr. CAIN. Well, I would certainly say that a program along that line could be designed, and I think my point of argument or point of view here would be that once the Government has decided essentially what kind of plan it wants to make available to its employees and retirees, that you ought to have private carriers who would participate in that risk, compete for the opportunity to offer it, as opposed to having the Federal Government self-insure it.

Senator STEVENS. Well, I am going to go back to CRS and ask them to do some more studies. I agree, we were all wrong on the assumption that most employees would take the low option. Why don't we look at it from the point of view, instead of saying we assume they will take the low option this is your option that is going to be paid for by the Government.

Now, if you want to go beyond that, we are willing to participate with you, and the Government will pay a portion of that increased cost for insurance to go beyond the low option, but you are going to pay more of it than the Government, because the Government is already paying the fixed cost of the low option. If you want to go to the high option, or anything more, you are going to have to pay a portion, but we will share that as employer with you.

Mr. CAIN. To a fairly large extent the program currently operates essentially in that way.

Senator STEVENS. It was supposed to, but many employees didn't choose the low option.

Mr. CAIN. Well, but at the present time now most of them have. In our plan, for example, we have a high option and a standard option. We have got about 300,000 in high option and about 1.3 million in our standard option. And it is primarily because the high option price is much higher and the Federal Government is only paying about 40 percent of the high option cost. You are, however, paying about 75 percent of the standard option. So it is clearly economically painful for anybody to choose the high option, and the Federal Government is containing its own costs in that example.

Senator Stevens. Well, I didn't know it changed that much, but I do want to review those figures and see if we can tie a single option into a cafeteria plan and have the additional coverage beyond a cafeteria plan single option be something that is available but at a substantial cost to the employee as compared to the employer.

Senator Pryor. A couple of questions, Mr. Cain, and then we will let you go.

Would Blue Cross and Blue Shield rather deal with the Federal Government or would you rather insure General Motors or IBM? Whom do you prefer?

Mr. CAIN. That is an awkward question. [Laughter.] We have been in the Federal employees program now from the beginning. I will tell you that it is our single largest account and we value it very highly. It has its problems. I will certainly admit that. And dealing with the Federal Government is not like dealing with GM. And let me just say, they are two different kinds of organizations.

Senator Pryor. I do not know the answer to this question. Why did Aetna decide they didn't want to deal with the Federal Government any more?

Mr. CAIN. Well, of course, I can't speak for Aetna. I will tell you what I think. I think that Aetna saw a very large financial risk just around the corner and decided that it hadn't the tools to handle it, and it departed from the program while it was still comparatively healthy. Interestingly enough, a lot of people say that there isn't much risk for carriers in this program. I wonder why Aetna left if that is the case.

Senator Pryor. I have wondered about this myself. I do not know the answer.

Mr. Cain, I want to thank you for coming today. I think there will be some follow-up questions, and we very much appreciate your presence.

We will put your full statement in the record. Thank you Mr. Cain.

We will next call Mr. Robert Pfotenhauer, who is the President and Chief Executive Officer of the Group Health Association, Inc. Mr. Pfotenhauer, we are very grateful for your appearance this morning. We look forward to your statement.

If I could, I would like to ask you to summarize your statement. The full text of your statement will be placed in the record.

TESTIMONY OF ROBERT P. PFOTENHAUER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION, INC.[1]

Mr. PFOTENHAUER. Thank you, Mr. Chairman. My name is Robert Pfotenhauer and I am President and CEO of Group Health Association. We are a not-for-profit, federally qualified HMO which serves the Washington metropolitan area. We are a staff model HMO, and we were started, in fact, in 1937 by a group of Federal workers. We now serve over 155,000 members, including nearly 62,000 Federal workers and their dependents.

I am here today on behalf of Group Health Association of America. GHAA is the oldest and largest trade association representing the HMO industry, and represents nearly 75 percent of some 591 HMOs nationally. These HMOs currently enroll nearly 35 million Americans.

I would like to talk specifically about the OPM proposal and, summarize my remarks. I think clearly the HMO industry, as you know, provides a very comprehensive benefit package in exchange for a fixed monthly premium. HMOs typically have very few deductibles and, copayments typically are very much lower than traditional indemnity insurance. Preventive care services are provided in a very broad form and items such as copayments for prescription drugs also are considerably lower than what people would typically pay under indemnity insurance.

Not only are HMOs known for providing a comprehensive set of benefits, but their cost-sharing is very different than traditional insurance. As I mentioned, the coinsurance typically is quite a bit lower than typical indemnity carriers.

In terms of the reform of FEHBP, the question that we ask of ourselves is the program serving the needs of Federal workers, and is the nature of the program such that it offers HMOs an opportunity to participate in a manner compatible with our delivery system. In our view, the answer to both of these questions is yes.

Does that mean that there aren't problems with the current program? Of course not. GHAA believes that there are some positive changes that can be made to the program, but that a complete overhaul of the system is probably unnecessary and might prove disruptive or even have unintended negative effects.

We feel very strongly that the focus of any discussion of reform should remain the Federal employee and reform should not be viewed simply as an opportunity to produce cost savings at the expense of the Federal workers. Our specific concerns about the OPM reform proposal relate to two changes which directly affect HMOs—the minimum benefit standard and rating.

Minimum benefit standards and rating changes are being discussed to address the question of risk selection, and I would like to make some comments regarding that. First, because HMOs offer a very comprehensive benefit package there is literally something for everyone in that benefit package, from prescription drug coverage with little or no copayment to very comprehensive maternity and well-baby care. In fact, I think statistics will indicate that HMOs enroll a disproportionate share of women in the childbearing years specifically because of the excellent maternity coverage. In insurance parlance, this would be viewed as adverse selection, given that their cost is in fact higher.

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[1] See p. 133 for Mr. Pfotenhauer's prepared statement.

As far as the annuitant population, it is true that a majority of the annuitants have been clustered in the high option of the Governmentwide plans. When most of these people were younger and active employees, their choices of health plans did not include many HMOs, and while this is no longer the case, change may be something that these individuals are unwilling to undertake. HMO studies have found that the elderly, who typically have long established relationships with their own physicians, are least likely to change enrollment to HMOs. It is worth noting, however, that among the HMOs which have participated in FEHBP the longest, their percentage of annuitants is representative of the annuitant population generally in the program. The recent TPF&C study indicated, for example, that Kaiser in the northern and southern California regions had 33 and 28 percent of annuitants in their total Federal population. In my on plan, started here in 1937 by Federal workers, nearly 30 percent of our 62,000 Federal members are annuitants.

Based on satisfaction surveys conducted by many of the GHAA plans, we have found that once enrollees have stayed with an HMO for a period of time they tend to remain and they will age in and become older and sicker and in fact have higher experience.

GHAA does support the concept of a minimum benefit package. However, because HMO first dollar coverage is so different than traditional indemnity coverage under FEHB, requiring identical benefit packages between HMOs and the fee-for-service plans may not be appropriate. In addition, many of the HMOs which participate in FEHBP are federally qualified HMOs, which means that they are required by Federal law to offer minimum benefits which are quite comprehensive. These requirements also establish limits on the amount of coinsurance that an HMO may charge.

We would request that any changes in minimum benefit levels take into consideration the requirements of the Federal HMO Act. Therefore, the OPM proposal that establishes a separate supplemental benefit should not apply to HMOs because their benefit packages already include most of these supplemental benefits. GHAA, in fact, has put together an industry working group on the issue of a separate minimum benefit standard, and we would be happy to work with you, Senator, and your staff to develop an appropriate benefit package for HMOs which would be compatible to the indemnity coverage.

On the issue of rating, GHAA opposes the proposal by OPM for cross-subsidy of rates. Although they give little detail, OPM suggests that HMO rates be adjusted downward or that they add premium loading to create a flow of funds to the indemnity plans. First of all, this proposal completely ignores how the current process works. HMOs typically use community ratings, which means that their rates already are adjusted for population characteristics. There is no need, in our mind, for a second adjustment to those rates. Second, OPM's assumption is that all HMOs have lower utilizers and therefore OPM should adjust the Government's contribution to those plans based on OPM's data on the age and sex composition of that HMO's enrollment. Age and sex may not be good predictors of health status and may not necessarily be related to the specific cost experience of that group.

To address OPM's concerns about this issue, we suggest following HMO industry practices in rating. HMOs currently use three methods of rating: Community rating, community rating by class, and adjusted community rating, otherwise known as ACR. The ACR rating is a new type of rating that was added and allowed by the HMO Act amendments of 1988 to respond to employer pressures for a system that could use characteristics of a specific employer group, including actual experience. Allowing the FEHB program to use ACR will allow HMOs to take into account the actual experience of their Federal enrollees if they desire to use this rating method.

To help address the problems associated with Medicare eligible beneficiaries, GHAA has two specific recommendations. First, there should be a separate medigap option available that HMOs should be able to offer on the same basis as indemnity carriers. And second, Medicare eligibles should be able to enroll under a Medicare TEFRA risk contract without penalty. Today under the TEFRA Medicare risk program HCFA contracts with some 90 HMOs that enroll approximately one million Medicare beneficiaries, and under this risk program HMOs provide a benefit package that includes benefits required under Medicare plus supplemental benefits. Most HMOs charge a monthly premium which buys out all of the deductibles and coinsurance under Medicare Part A and B. The individual must still pay the Part B premium, however.

Currently FEHBP and the Medicare risk program are completely incompatible. If an annuitant would opt to enroll in the HMO Medicare risk program, they would need to disenroll from FEHBP in order to avoid paying for duplicate benefits, and would be ineligible to re-enroll in FEHBP. OPM and HCFA have discussed this issue, but as of yet without a satisfactory resolution. GHAA would like to work with this Subcommittee to correct this problem.

Once again, Mr. Chairman, let me thank you for the opportunity to share our views today. We believe that HMO participation in the FEHBP program has been valuable to Federal workers as well as to the Federal Government in providing a comprehensive, quality, and cost effective health care option. And we know that many others agree with us, given the outlines of the reform proposals presented to the Congress and OPM. We would like to work with you as the deliberations proceed.

Senator PRYOR. Thank you very much for your statement.

Did you hear the statements given earlier by Ms. Newman and Mr. Smith on the OPM proposal?

Mr. PFOTENHAUER. Yes.

Senator PRYOR. Do you have any way of knowing, or does your organization have ways of crunching budget figures? Do you have any sense that they are on target with their budget projections?

Mr. PFOTENHAUER. We have not completed any economic analysis of the proposals. I think that the potential discrepancies that have arisen this morning between the CRS staff and the OPM staff are certainly appropriate ones to continue to pursue. I would have many of the same questions that the CRS staff raised.

Senator PRYOR. All right. Well, I just want to thank you once again for being here. We do have several members who have requested the opportunity to submit questions in writing. You have a unique operation, and I think the ideas that you put on the table this morning are very constructive. We appreciate it very much. Thank you.

I will call as our last witness Catherine Austin, the Assistant Secretary for Personnel Administration from the State of Maryland. Ms. Austin, we appreciate your being here.

TESTIMONY OF CATHERINE AUSTIN, ASSISTANT SECRETARY FOR PERSONNEL ADMINISTRATION, STATE OF MARYLAND

Ms. AUSTIN. Thank you, Senator.

Senator PRYOR. Should you have a written statement, the entirety of that statement will be placed in the record. Should you care to summarize your statement, we would be very appreciative.

Ms. AUSTIN. Senator, I do not have a prepared statement.

On behalf of Governor Schaefer and Secretary Ford, Secretary of Personnel, I would just like to take a moment to thank you and express our appreciation for being invited down here. It was only 3 years ago the State of Maryland was struggling with the very same issues that are facing you today. We had a program that was out of kilter, so to speak, with what was going on in the marketplace in terms of attracting employees, and what we were finding was that we were becoming the employer of last resort instead of the employer of first choice, and one of the areas that we needed to begin to address very quickly was the area of benefits. One of the areas that we cannot compete with the private sector, obviously—and the Federal Government is no different than we are, we believe—and that is in the area of salaries. We cannot keep up with salaries. So the only thing we do have really to offer our employees are quality benefit packages that are responsive to their particular needs in life.

We entered 1987 with a program that was basically a health insurance program. There was nothing else. There was no dental. There was vision, there was prescription, but it was packaged into various programs. There was a proliferation of HMOs which did not support our employee assistance program. There was no personal accident dismemberment, no life insurance, long-term care, no catastrophic. There was nothing. And we were getting a substatial increase in the demands from women, particularly, who wanted more protecting for their families but who were also faced with being single parents with four children and making an average of $25,000 a year. Tough choices.

We elected to move into a flexible benefit program. We implemented it over a 3-year period. We spent the first 2 years of that period rounding out our program, adding options that were 100 percent employee paid, allowing employees to deduct or pay for their premiums on a pre-tax basis, introducing health care spending accounts, dependent care spending accounts, and when all was put in place, by the end of 1989 an employee who had realized a 4 percent increase in salary over the previous fiscal year actually realized a 6 percent increase in disposable net income with which to purchase other forms of insurance.

And what we have seen is our health care spending accounts go from an initial enrollment of 1,200 people to 12,000. We have seen our dependent care spending accounts increase from an initial enrollment of I believe right now it has gone from 400 to 1,200 people. We have seen a dental program enroll 19,000 people, personal accident dismemberment enroll 20,000, all at no expense to the State of Maryland. And so I would really like to suggest to you—and it was nice to hear Senator Stevens speak to it—that flexible benefits are an alternative. They do not need to cost substantial amounts of money to provide the kind of flexibility you are working for. One area—and I feel like a little boy who has thrown a lightweight ball into the ocean, you think that you have got a benefit problem solved and you blink and the ball is over here, so you have got to move over there. And we in Maryland share your concern, Senator, with the increase in prescription drug costs. We have experienced a 52 percent increase in our prescription drug program this past year.

Senator PRYOR. In what time span was that 52 percent increase?

Ms. AUSTIN. Within 1 year, and those rates that were—in fact, they are guaranteed over a period of 2 years, we insisted on that—but they were rates that were established prior to approval of AZT for the HIV identified person as opposed to the person with full-blown AIDS, and prior to the approval of the two new drugs out for Parkinson's disease, which are also going to be substantial.

Senator PRYOR. Ms. Austin, were these increases in prescription drug prices solely the price increases leveled by the manufacturer?

Ms. AUSTIN. We believe so. We believe so, and we were heartened to hear that Congress was addressing that issue.

Senator PRYOR. Well, I don't think we are addressing it. I am going to try to address it, but it is hard to get attention on some issues, as you know. Evidently, the morale of the public employee in the State of Maryland with regard to this very splendid health system is pretty high, is that correct?

Ms. AUSTIN. We believe it is. We get very little complaints. We have actually gotten some employees who have decided to stay with the State of Maryland solely because of the options available to them. We have gotten feedback from our employees. Not everything is perfect. You are always going to have—in a benefit period you are going to have people who are unhappy because something wasn't paid for 100 percent. But what we are seeing with our employees is an interesting shift. They are moving from the traditional first dollar program, because of costs out of their pocket, and they are willingly moving into a preferred provider program as an alternative to our HMOs, because not everyone wants an HMO. We do not have national HMOs within the State of Maryland, so when they leave state service and they move, let's say, to Florida on retirement, they need some option available to them.

We have seen a 25 percent shift from the traditional first dollar option to the preferred provider option directly, and to where now we only have about 25 percent in the first dollar option.

Senator PRYOR. How many States have the pre-tax system?

Ms. **Austin**. I believe that right now only about six have them. Tennessee has it, Hawaii, California, and Ohio may have it. I know New York is looking at it, but we are among the minority.

Senator **Pryor**. How many States are calling you wondering about what you are doing in Maryland and how they could do the same? For example, have you heard from Arkansas?

Ms. **Austin**. No, I have not heard from the good State of Arkansas. But I am going to Pennsylvania next month, and I know I am going to New York on the following month to talk about what we have done in Maryland.

Senator **Pryor**. Well, this has been a very positive aspect of this hearing this morning. We appreciate your being here to bat cleanup for us and give us a little hope. I think that not only other States might take a look at the State of Maryland's program, but also there are some concepts that we can adopt in the Federal system.

Ms. **Austin**. Thank you.

Senator **Pryor**. We want to thank you very much for your attendance and for your very, very constructive testimony. Thank you so much.

Ladies and gentlemen, our hearing stands adjourned. Thank you all for participating.

[Whereupon, at 11:35 a.m., the Subcommittee adjourned subject to the call of the Chair.]

APPENDIX

STATEMENT OF
HONORABLE CONSTANCE BERRY NEWMAN
DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT

before the

SUBCOMMITTEE ON FEDERAL SERVICES, POST OFFICE, AND CIVIL SERVICE
COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

on

REFORMING THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

APRIL 20, 1990

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR GIVING ME THIS OPPORTUNITY TO DISCUSS FURTHER THE RECOMMENDATIONS OPM RECENTLY SUBMITTED TO CONGRESS CONCERNING NEAR AND LONG-TERM STRATEGIES FOR IMPROVING THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM. WE WELCOME DISCUSSION OF WHAT BASIC PROGRAM STRUCTURE WOULD BEST SERVE GOVERNMENT AND ENROLLEE INTERESTS IN TERMS OF EQUITY FOR ALL SEGMENTS OF THE ENROLLEE POPULATION, COST EFFICIENCY, AND MAINTAINING APPROPRIATE GOVERNMENT-ENROLLEE COST-SHARING.

THE FEHB PROGRAM, THIS COUNTRY'S LARGEST EMPLOYER-BASED HEALTH INSURANCE PROGRAM, INVOLVES 9 MILLION ENROLLEES--EMPLOYEES, RETIREES, AND ELIGIBLE DEPENDENTS--APPROXIMATELY 320 PARTICIPATING INSURANCE PLANS AND HEALTH MAINTENANCE ORGANIZATIONS (HMO's), AND AN ANNUAL BUDGET OF $12 BILLION. GIVEN THE COST OF HEALTH CARE TODAY, HEALTH INSURANCE HAS EVOLVED INTO A KEY COMPONENT OF EMPLOYEE COMPENSATION AND, AS

SUCH, IS AN IMPORTANT FACTOR IN ATTRACTING AND RETAINING A QUALITY WORKFORCE.

FOR NEARLY 20 YEARS FOLLOWING THE FEHB PROGRAM'S INCEPTION IN 1960, IT WAS ESSENTIALLY STABLE AND AFFORDED MOST ENROLLEES A SATISFACTORY CHOICE AMONG INSURANCE ALTERNATIVES PROVIDING VERY COMPREHENSIVE PROTECTION AGAINST HEALTH CARE EXPENSES. HOWEVER, IN THE LATER 1970's, AS THE NUMBER OF FEHB PLANS PROLIFERATED, AND NATIONAL HEALTH CARE COSTS ESCALATED RAPIDLY, AND ANNUITANTS CAME TO REPRESENT A SIGNIFICANT PERCENTAGE OF PROGRAM ENROLLEES, INHERENT STRUCTURAL PROBLEMS BEGAN TO SURFACE.

IN THE LAST TWO YEARS, AS YOU KNOW, THE TOWERS, PERRIN, FORSTER, AND CROSBY STUDY ASSERTED FEHB PROGRAM DEFICIENCIES AND ESSENTIALLY ATTRIBUTED THEM TO THE PROGRAM'S PROPENSITIES FOR RISK SEGMENTATION AND ADMINISTRATIVE INEFFICIENCY. OVER THE SAME 2-YEAR TIMEFRAME, OPM COMPILED A SUBSTANTIAL BODY OF INFORMATION AND OPINION WHICH WAS REFLECTED IN OUR RECOMMENDATIONS TO YOU UNDER PUBLIC LAW 101-76.

OPM IS CONTEMPLATING LONG-TERM, COMPREHENSIVE FEHB REFORM THAT WILL BE DESCRIBED LATER. HOWEVER, THESE REFORMS WILL NOT BE POSSIBLE IMMEDIATELY UPON ENACTMENT OF AUTHORIZING

LEGISLATION. OF NECESSITY, THERE WILL HAVE TO BE A TRANSITION PERIOD DURING WHICH NUMEROUS ADMINISTRATIVE ACTIONS MUST BE ACCOMPLISHED. IN THE MEANTIME, IT IS IMPORTANT THAT THE PRESENT PROGRAM BE MADE AS FINANCIALLY STABLE AND COST EFFICIENT AS POSSIBLE AND THAT, WHEREVER POSSIBLE, WE BEGIN TO IMPLEMENT REFORM OBJECTIVES, TO ENSURE THE SMOOTHEST TRANSITION.

AS INDICATED IN OUR MARCH 1 LETTER, THE ADMINISTRATION PROPOSES TWO OPTIONS: EITHER TO STABILIZE GOVERNMENT EXPENDITURES BY USING A WEIGHTED AVERAGE FORMULA FOR DETERMINING ITS CONTRIBUTION UNDER THE FEHB PROGRAM, OR TO ADOPT A COMBINATION OF LEGISLATIVE AND ADMINISTRATIVE INITIATIVES. BOTH METHODS WOULD REACH THE FY 1991 BUDGETARY SAVINGS TARGET OF $850 MILLION.

AS DESCRIBED IN OUR MARCH 1 LETTER, THE "WEIGHTED AVERAGE" FORMULA WOULD SUBSTITUTE, AS A CAP ON THE MAXIMUM DOLLAR AMOUNT THE GOVERNMENT WOULD CONTRIBUTE TO EACH EMPLOYEE'S PLAN, 60 PERCENT OF THE WEIGHTED AVERAGE OF ALL PLANS FOR 60 PERCENT OF THE SIMPLE AVERAGE OF "BIG SIX" CARRIERS. TODAY, THE ORIGINAL "BIG SIX" APPROACH NO LONGER REFLECTS ACTUAL USAGE. THE WEIGHTED AVERAGE APPROACH BETTER REFLECTS THE ORIGINAL INTENT OF THE FEHB LEGISLATION. THE USE OF THE WEIGHTED AVERAGE FORMULA IN FY 1991 WOULD ACHIEVE $850 MILLION IN SAVINGS.

IN ADDITION, WE HAVE ALSO PROPOSED AN ALTERNATIVE MIX OF LEGISLATIVE AND ADMINISTRATIVE INITIATIVES WHICH COULD ALSO ACHIEVE THE $850 MILLION IN SAVINGS WHILE ALSO DIRECTLY BENEFITTING ENROLLEES. THIS SECOND ALTERNATIVE ANTICIPATES THREE LEGISLATIVE ACTIONS:

1) PREEMPTION OF STATE PREMIUM TAXES, BY MOVING FEHB PLANS NOW SUBJECT TO SUCH TAXES TO ESSENTIALLY A SELF-INSURED BASIS;

2) UNIFICATION OF THE TREASURY-HELD CONTINGENCY RESERVES FOR NON-HMO FEHB PLANS; SUCH PLANS INSURE THE MAJORITY OF FEHB ENROLLEES UNDER CONTRACTS WHICH ALLOW GAINS OR LOSSES TO BE CARRIED FORWARD FROM YEAR TO YEAR, MAKING THE TRUE RISK FOR THIS CLASS OF PLANS SO MINIMAL AS TO MAKE PLAN-BY-PLAN RESERVE ACCUMULATION EXCESSIVE; AND

3) CHANGE THE FEHB GOVERNMENT CONTRIBUTION FORMULA, FROM 60 PERCENT OF THE "BIG SIX" AVERAGE HIGH-OPTION RATES, TO 67 PERCENT OF THE PROGRAM-WIDE WEIGHTED-AVERAGE RATES, WHICH EFFECTIVELY YIELDS AN AGGREGATE GOVERNMENT SHARE OF PREMIUMS OF 65 PERCENT.

ADMINISTRATIVE ACTIONS WHICH OPM INTENDS TO UNDERTAKE IN

CONJUNCTION WITH THIS ALTERNATIVE PROPOSAL FOR REVISING FEHB FINANCING FOR FY 1991 WOULD BE CONSISTENT WITH THE BROADER FEHB REFORM OBJECTIVES OUTLINED IN OUR LETTER OF MARCH 1, 1990, AND WOULD LESSEN THE RATE OF INCREASE IN ENROLLEE PREMIUMS. OUR MARCH 27TH CALL LETTER TO FEHB INDEMNITY PLAN CARRIERS REQUIRES THAT THEY TAKE STEPS TO ASSURE THAT PROPER BENEFITS COORDINATION TAKES PLACE IN CASES WHERE MEDICARE BENEFITS ALSO APPLY AND THAT COMBINED FEHB/MEDICARE PAYMENTS DO NOT EXCEED MAXIMUM CHARGE LIMITS SET BY LAW FOR MEDICARE PURPOSES. WE ARE ALSO MANDATING THAT APPROPRIATE COST-CONTAINMENT TECHNIQUES, SUCH AS LARGE-CASE MANAGEMENT, BE UNIFORMLY ADOPTED BY PARTICIPATING CARRIERS. ASSESSMENTS OF THE EFFECTIVENESS OF COST-CONTAINMENT AND MEDICARE COORDINATION WILL BE REFLECTED IN THE PROFIT CHARGES ACCORDED TO EACH CARRIER.

AS MY MARCH 1ST LETTER MADE CLEAR, IT IS IMPERATIVE THAT, WHICHEVER APPROACH TO NEAR-TERM FEHB REFORM IS TAKEN, WE ACHIEVE THE FEHB BUDGET SAVINGS INCLUDED IN THE PRESIDENT'S FY 1991 BUDGET OF $850 MILLION.

OVER THE LONGER TERM, COMPREHENSIVE FEHB REFORM MUST FOCUS ON CHANGING THE BASIC PROGRAM STRUCTURE. IT MUST ENSURE THAT ENROLLEES HAVE CLEAR, UNDERSTANDABLE HEALTH PLAN CHOICES. IT MUST PROVIDE EQUITY FOR EMPLOYEES AND RETIREES WITH RESPECT

TO BENEFITS FOR THE MONEY EXPENDED. IT MUST FACILITATE COST-EFFICIENT OPERATION OF PLANS, BENEFITING BOTH ENROLLEES AND THE GOVERNMENT.

A REFORM STRUCTURE, WHICH WE OUTLINED IN OUR MARCH 1ST LETTER, BUILDS DISTINCT RISK POOLS FOR EMPLOYEES AND ANNUITANTS. BENEFIT LEVELS, PREMIUMS, AND GOVERNMENT CONTRIBUTIONS WOULD VARY BETWEEN THE RISK POOLS.

EMPLOYEES WOULD HAVE A CHOICE AMONG A LIMITED NUMBER OF GOVERNMENTWIDE, SELF-INSURED INDEMNITY PLANS PROVIDING BASIC AND/OR SUPPLEMENTAL BENEFITS APPROPRIATE FOR THAT GROUP. RETIREES WOULD BE COVERED BY MEDICARE AND A MEDIGAP PLAN WHICH WOULD FILL IN THE CO-PAYMENTS AND DEDUCTIBLES NOT COVERED BY MEDICARE, PERMITTING FULL PAYMENT OF CHARGES UP TO MEDICARE'S APPROVED AMOUNT. ANY RETIREES OVER AGE 65 WITHOUT AUTOMATIC MEDICARE ELIGIBILITY WOULD BE AFFORDED AN OPPORTUNITY TO ELECT VOLUNTARY MEDICARE ENROLLMENT AND COMBINE THIS WITH FEHB MEDIGAP COVERAGE. RETIREES UNDER AGE 65, AND THOSE OVER AGE 65 WHO MIGHT NOT WISH TO PARTICIPATE IN THE MEDICARE PROGRAM, WOULD BE PROVIDED ESSENTIALLY THE SAME LEVEL OF COVERAGE AS THEIR MEDICARE-ELIGIBLE COUNTERPARTS UNDER AN ALTERNATIVE FEHB PLAN.

WE WOULD ALSO OFFER THE RISK POOLS HMO ALTERNATIVES IN ANY

GIVEN AREA WHICH SATISFY STANDARD HMO BENEFIT REQUIREMENTS. OPM WOULD ADJUST HMO RATES TO PROVIDE APPROPRIATE CROSS-SUBSIDIES BETWEEN THE INDEMNITY PLANS AND THE HMO's TO MINIMIZE RISK SEGMENTATION.

THE GOVERNMENTWIDE PLANS WOULD BE ADMINISTERED UNDER CONTRACTS WITH COMPETITIVELY SELECTED REGIONAL THIRD PARTY ADMINISTRATORS (TPA'S) WHO WOULD BE RESPONSIBLE FOR PROCESSING CLAIMS AND IMPLEMENTING COST CONTAINMENT MEASURES. THE SELF-INSURED NATURE OF THE PROGRAM WOULD ELIMINATE CURRENT STATE PREMIUM TAX LIABILITIES AND SIGNIFICANT AMOUNTS IN RISK CHARGES AND CARRIER PROFITS.

WE HAVE LAID OUT OUR PLAN IN MY MARCH 1, 1990 LETTER TO CONGRESS. IN ADDITION, A WHITE HOUSE TASK FORCE ON FEDERAL EMPLOYEES HEALTH BENEFITS HAS RECENTLY BEEN COMMISSIONED TO STUDY STATE-OF-THE-ART HEALTH BENEFITS STRUCTURES AND COST-CONTAINMENT MECHANISMS, EMPLOYER PRACTICES, AND HEALTH CARE DELIVERY SYSTEMS, FOR PURPOSES OF RECOMMENDING MODELS WHICH SEEM APPLICABLE TO THE FEDERAL EMPLOYEE PROGRAM.

I ALSO WANT TO MENTION THAT THIS YEAR'S FEHB CARRIER CALL LETTER ANNOUNCES OUR INTENTION TO CONVERT THE CONTRACT TERM TO A FEDERAL FISCAL YEAR BASIS. THIS WILL ELIMINATE CERTAIN ADMINISTRATIVE COMPLICATIONS ASSOCIATED WITH THE PRESENT LACK

OF CONFORMITY AND WILL MOVE THE ANNUAL OPEN SEASON AWAY FROM THE YEAR-END HOLIDAY SEASON. THE NEXT CONTRACT TERM WILL BE 21 MONTHS, BEGINNING JANUARY 1, 1991. BENEFITS WILL REMAIN IN PLACE FOR THE ENTIRE PERIOD. RATES WILL BE ADJUSTED BEGINNING JANUARY 1, 1992. OF COURSE, AN OPEN SEASON FOR CHANGING HEALTH PLANS WILL PRECEDE THIS RATE ADJUSTMENT. THE FISCAL YEAR 1993 CONTRACT TERM WILL BEGIN ON OCTOBER 1, 1992. NO NEW PLANS WILL BE ADMITTED TO THE PROGRAM FOR THE CONTRACT TERM OF JANUARY 1 TO OCTOBER 1, 1992.

IN CONCLUSION, I LOOK FORWARD TO WORKING WITH THE CONGRESS TO DISCUSS THE IMPORTANT ISSUES CONFRONTING OUR EMPLOYEE HEALTH PROGRAM. I WILL BE HAPPY TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

APR 4 [illegible]

Honorable David Pryor
Chairman, Subcommittee on Federal
Services, Post Office and Civil Service
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Pryor:

This is in response to your request for additional information concerning our recommendations for reforming the Federal Employees Health Benefits (FEHB) Program. I regret that you found our proposal lacking the specificity you were seeking and trust that the information we have assembled in response to the various questions you have raised will serve to fill in the relevant portions of the overall proposal.

We believe that the structure of the reform proposal is most important and that the details can and should vary over time to complement changes in the health care delivery system. Quality concerns about health care are becoming increasingly important to more and more beneficiaries. We need to be able to adapt FEHB to assure that quality health care is available to the Federal workforce and their families.

After design of a new structure, resource constraints (which determine the sources of funding) become a key measure for acceptable legislation. We have advised you of the expected resource levels and wish to renew that advice. The accompanying detailed responses should not be viewed as moderating our fiscal concerns.

I look forward to working with you and your colleagues in Congress on this significant endeavor. My responses to the specific questions raised in your letter are enclosed. There are, of course, a number of issues to be resolved as we proceed toward a final design and these resolutions could affect the details provided in our responses.

OMB advises that from the standpoint of the Administration's program, there is no objection to the submission of this letter.

Sincerely,

Constance Berry Newman

Constance Berry Newman
Director

Enclosures

1. Does this proposal differ from the recommendations which OPM originally submitted to the Domestic Policy Council (DPC)? If so, please list and explain all changes.

Response #1

The recommendations we submitted to Congress on March 1 constitute the Administration's views as to how the FEHB Program could be restructured to deliver the maximum level of benefits per premium dollar. As you might expect, developing the recommendations was an iterative process both within OPM and between OPM and other interested and informed parties such as OMB, HHS, and the DPC. It is not possible to identify the specific contributions that each party made during the process. The original submission to the DPC was in and of itself the product of discussions within the Administration.

2. Please provide the Subcommittee copies of any backup or illustrative packages mentioned by Dr. Smith that might assist us in understanding OPM's proposal.

Response #2

OPM's reform recommendations specifically addressed the problems identified in the Towers, Perrin, Forster and Crosby and the Congressional Research Service studies -- risk segmentation and economic inefficiencies. Our reform recommendations focused primarily on a resolution of the primary and secondary problems of the program from a structural standpoint and was intentionally silent on many of the attendant design details. Our recommendations were not constructed in such a manner that we had a specific benefits package with corresponding subscriber and Government contribution rates predetermined. Indeed, our goal was to establish a programmatic structure that would be compatible with a variety of benefit packages and delivery modes and thus durable for long-term use. Therefore, we simply may not have the level of detail associated with our recommendations you may be seeking at this time.

We were more concerned with such basic structural components of reform as self-insurance vs. the more traditional manner of contracting with carriers found under the current program, the role of Third Party Administrators (TPAs), the composition and number of risk pools, and equity for the various groups of subscriber participants under a reformed program. I realize the potential benefits and rates under a reformed program are of particular interest. However, it is important that the Government, just as in the case of any other employer, retain broad discretion on benefit structures and not be locked in-to a finite benefits structure so as to keep pace with trends in private industry and take advantage of marketplace changes. As you know, a Task Force on Federal Employees Health Benefits has been established within the DPC's Health Policy Working Group. We will be looking to that Task Force for input when we begin to assemble firm proposals on benefits to go along with the reform structure. We strongly believe the major challenge before us now and in the months ahead is reaching a consensus on how the program should be restructured. Enclosed is a chart describing various rate and benefit packages which illustrate what will also be possible under a reformed program.

3. Your proposal discusses the establishment of distinct risk pools for employees and retirees. Yet, you propose five self-insured indemnity packages. How are these packages to be established vis-a-vis the distinct risk pools? Will the five indemnity packages be considered as one risk pool and used to calculate cross-subsidies? How many plans will be provided for retirees without Medicare? How many plans will be provided for Medicare-eligible retirees?

Response #3

Under our reform recommendations, two distinct risk pools -- one for employees and one for retirees -- would be created. Employees could have five different levels of coverage from which to choose. Although we believe it is premature to focus our attention too closely on the benefit packages, we envision two of these indemnity packages could be designed to provide varying levels of coverage for basic benefits and another two packages could offer a supplemental component in addition to the basic benefits. A fifth package covering supplemental benefits only is also anticipated. For premium rating purposes for the employee risk pool, the experience of the four indemnity plans providing basic benefits would be aggregated. Cross-subsidies could exist between these benefit packages to account for any risk segmentation which occurs between them.

All retirees would comprise the second risk pool and their total level of coverage would be the same for basic benefits as they aged from pre-Medicare days (i.e., before age 65) to post-Medicare days. There would be one benefit package for retirees based on the combined benefits available under Medicare and a Medicare supplemental policy. When the enrollee became

Medicare-eligible, the same total level of payment would continue to be provided but the major portion would be paid by Medicare and the remaining portion paid by the reformed program. Prior to reaching age 65, the total would be paid by the reformed program. Just as total benefits would not change, total premiums would not change. However, at the time Medicare eligibility is reached, premiums to our program would be reduced by the exact value of the Part B premium which would become payable to Medicare. This contrasts sharply with the current program whereby Medicare enrollees pay Part B premiums in addition to the same FEHB premium as other enrollees with no resulting reduction in their FEHB premium.

All retirees could choose to add supplemental benefits to their basic benefits. The supplemental package would likely be strong in the areas of interest to an older population. Hearing, vision, skilled nursing, and expanded home health would probably be among the benefits offered.

4. Do you have the results of the OPM survey of annuitant and employee attitudes about the federal health insurance program? Were these results used in designing your reform proposal? Please identify the major attitudes of each group and provide the findings of your survey.

Response #4

We received the results of the survey while we were developing our recommendations and used those results to verify that key aspects of our proposal were not inconsistent with the expressed attitudes of employees and annuitants. For example, the majority of employees and annuitants said they favored a simplified program with standardized benefits as well as discrete benefit packages specifically tailored and priced for employees, annuitants and Medicare covered annuitants. I have sent you a copy of the report from Science Management Corporation which provides detailed information on the results.

5. Under the OPM proposal, who will design the benefit packages? How many staff years will be devoted to benefit design? Are these staff resources currently onboard? What functions do they perform now?

Response #5

OPM's current staff of Health Benefits and Contracts Specialists and Actuaries, numbering ten full-time equivalent positions, who now negotiate benefits for the 20 fee-for-service plans in the FEHB Program will design the benefits packages. OPM staff also has considerable expertise in HMO benefits design and can provide a standard prepaid package using in-house resources.

6. The OPM proposal recommends that the Federal government "...self-insure to eliminate state premium taxes and significant amounts in risk charges and duplicative carrier profits." Would OPM self-insure with or without reserves? If reserves are used, how would the reserves be set and regulated?

Response #6

Even though we would be self-insured, prudence requires that we set aside and maintain an appropriate level of financial reserves. It is clear that under a self-insured program, the level of reserves would not have to be as high as under the existing program. The reserves would probably be expressed as an amount equivalent to a percentage of premium income or claims expenses and reflected in OPM's regulations as is the current practice. Currently, we are considering a level of reserves approximating one month's claims and expenses as a goal.

7. If a health plan's cost exceeds income and the reserves are exhausted, how will the Federal government pay its claims? Would supplemental appropriations be required? Does the OPM proposal envision changing the basic appropriations structure for FEHBP?

Response #7

As we noted above, we would set the reserve level initially at a level we believe would be sufficient to guard against any major claims fluctuations and sufficient to guarantee the solvency of the benefit program. The preferred target would be one month's claims and expenses. This level could be adjusted later based on the experience of the program and the sufficiency of the reserves at that time. It is highly unlikely that we could miss our cost projections so dramatically under a self-insured program that the premiums would be insufficient to pay claims expenses and the reserves would eventually be exhausted if no further actions were taken. Since the FEHB Fund will be operated on a cash basis, it is important to note that there is a 2-to 3-month lag time between the actual provision of services and the payment of claims. Thus, a mis-estimate exceeding 24% would have to occur in any year before our ability to pay claims would be jeopardized. Therefore, we do not anticipate the need for any supplemental appropriations from Congress. More realistically, we would probably tend to be overly cautious and conservative in our rate-setting approach, especially during the first full year following reform.

8. What kind of staff increases does OPM envision to handle the contracting responsibilities of self-insurance? What kind of qualifications would you look for?

Response #8

We do not anticipate any staff increases due to self-insurance. Our health insurance actuaries currently evaluate the claims experience and demographics of the FEHB population as they negotiate benefits and premium rates with insurance carriers under the existing program. Our program and financial analysts routinely review the statistical and financial data produced in the FEHB Program. Thus, OPM possesses much of the data and expertise, and indeed already expends much of the effort normally associated with a self-insured program.

Under our recommendations for reform, we would be negotiating with a smaller number of contractors on a different range of issues. After the benefits and rates are determined, the real negotiating points will be the cost containment mechanisms.

9. The OPM proposal identifies a number of functions to be performed by "contractors" who will administer the self-insured indemnity benefit packages including claims processing and administering effective cost containment measures. Please identify at least five such "contractors" who now perform for the private contractors the same mix of functions contemplated by the OPM proposal and the companies for whom such services are performed.

Response #9

We believe it would be inappropriate to identify by name such existing contractors in the private sector since this could be viewed by some as an expression of preference of one over another on our part. However, as part of our research on Third Party Administrators (TPAs) and the role they currently play for other large employers in administering group health benefit programs, we identified and contacted a number of organizations which were performing functions we would expect of TPAs under a reformed FEHB Program. They were the organizations one would expect to be providing such services, insurance companies and affiliates, insurance underwriters and administrative services contractors. Indeed, the companies that could be expected to bid to insure the Program would also bid to be administrators. These organizations are currently serving a broad cross-section of private employers and public sector administrators both at the state and Federal level. Many of these same organizations play some role in the current FEHB Program.

We are persuaded that there is an ample source of contractors available to us once we can restructure the Program to accommodate the practice of obtaining only needed services. We would anticipate establishing rigorous standards for an entity to become qualified and for successful bidders to be closely scrutinized on past experience and current qualifications during the bidding/application review process.

10. Please provide a composite of the total Program reserves position over the past ten years. Identify the years when total reserves exceeded reserve targets and when total reserves were less than Program targets.

Response #10

The attached charts express FEHB reserves and contingency reserve payments since FY 1980 in terms of one month's premiums. Prior to 1986, overall reserve goals did not exist. Rather, the rate setting process focused on reserves maintained at the carrier level. Since 1986, the rate setting process has aimed at a reserve goal of 2 months of average claims costs. This goal was not absolute for any given year, but served as a target that the rate setting process worked toward. The data presented below clearly shows the rapid build up of reserves following the 1982 introduction of Program wide cost containment features i.e. co-payments and deductibles, to stem rapidly increasing premium costs. These cost containment features proved more successful than anticipated, resulting in excess reserves and leading to rebates and premium reductions in 1986/87. The rapid depletion of excess reserves accounts for the only years, 1986/87, in which reserve payments exceeded one month's premiums. This history of reserve payments in a Program in which reserves were segmented by plan and option over a period of very unstable health care costs shows that a one-month, unified, reserve will be a more than adequate margin for the FEHB Program.

FEHB Contingency Reserve Payments/
Balances FY 1980-1991
(Expressed as Month's Premiums)

Year	Reserve Balances (Curr Law)	Reserve Payments (Curr Law)
1980	2.5	0.53
1981	0.7	0.63
1982	0.9	0.64
1983	1.9	0.42
1984	3.8	0.72
1985	5.97	0.13
1986	2.6	2.1
1987	0.96	1.1
1988	0.86	0.61
1989	2.1	0.17
1990	2.0	0.1
1991	1.8	0.3

11. The OPM proposal suggests that very little risk exists in the current Program. Yet, the Subcommittee has received information that insurers have actually lost money when employee organization plans have changed underwriters. Please identify the underwriters who have lost money in FEHBP over the past ten years, with the amounts, by underwriter, and by year.

Response #11

Several underwriters lost money during the past ten years when they left the FEHB Program. I have enclosed a chart which details the losses by year and by plan of the three which left in a negative position. The totals for all years at the top of the page represent net losses over the ten-year period.

It is important to note that losses occurred because these insurers ceased to underwrite particular plans. In general, those plans had relatively small enrollments which made them especially vulnerable to adverse claims experience. The insurance companies knew the risk when they contracted with the respective carriers and sustained a normal business loss when those contracts were terminated. The total net loss, which when all amounts have been finally determined will be well under $100 million, represents a minute fraction of FEHB Program costs over a ten-year period.

12. Under OPM's proposal, retirees over age 65 could buy into Medicare. This opportunity currently exists so what is the new opportunity which OPM is offering? For those federal annuitants who are not covered by Medicare Part A and/or Part B, will the Federal government purchase Part A and pay the Part B premiums for them? Dr. Smith indicated that the penalties for signing up late would be waived. Do, you have a formal agreement on this with the Health Care Financing Administration and the Office of Management and Budget?

Response #12

Under our recommendations for reform, Federal retirees age 65 and older who are not covered by Medicare Part A or B could voluntarily buy-in to Medicare. [Retirees who buy-in Medicare coverage would be eligible for OPM's Medigap policy under the same conditions available to other Medicare participating Federal retirees.] Of course, retirees could continue their participation in FEHB under the same conditions that existed prior to their new Medicare status.

Specifically, Federal retirees age 65 and over who are not covered by Medicare Part A or B could elect to have the Government buy-in to Medicare for them. We have considered the option of having the FEHB Program purchase Part A coverage for these individuals from the Health Care Financing Administration (HCFA) if this buy-in occurs within a scheme that meets the overall cost constraints detailed in the President's FY 1991 Budget. Within such a plan, the retiree would be required to pay only the current Part B premium, exclusive of any penalties for late enrollment, to have full Medicare coverage. The FEHB premiums these retirees would otherwise be required to pay would be reduced by the equivalent of the Medicare Part B premiums. Therefore, they would not suffer any additional out-of-pocket premium expense for having obtained full Medicare coverage.

Of course, our final reform legislation will specifically detail any buy-in provision.

13. The OPM proposal states that the "contractors" under the reformed Program will administer effective cost containment measures such as pre-admission screening and case management. What will be different under the reformed Program from the pre-admission screening and case management that is administered now? Will the reform Program involve denial of benefits and payments unless all conditions are met or will the Program simply provide incentives to use the cost containment measures? Please provide further explanation on the type of case management procedures and other cost containment measures to be employed and cite examples of differences from the current Program.

Response #13

We plan to more fully implement such standard cost containment measures as pre-admission screening and case management. These measures are currently provided for in our contracts with various carriers but there is little incentive currently for the carriers to vigorously pursue them. Under the current Program, carriers are generally more concerned with attracting and retaining a certain market share. If they believe their current or potential subscribers view strict enforcement of such cost containment measures as troublesome or a disincentive to enrollment, the carriers have no real desire to effectively implement even the more traditional forms of cost containment. Under our proposal, the contractors will not be vying for market share. Effective implementation of proven cost containment measures will be one of the criteria by which contractors will be selected and retained in the reformed Program.

A combination of the "carrot-and-stick" approach will probably evolve for subscribers under our reform proposal. In some instances involving elective procedures, for example, we may tailor the benefits and procedures in such a way as to exclude or dramatically reduce payment if the cost containment procedures are not followed. In other circumstances, financial incentives such as a waiver of or reduction in the co-payments or deductibles for following prescribed procedures might be more appropriate. In any event, we plan to be mindful that our cost containment efforts do not pose impediments to subscribers obtaining the truly necessary health care services or serve only as punitive vehicles to transfer costs to subscribers. Our overriding consideration in this area will be to establish mechanisms whereby patients can be guided to the most appropriate and cost effective level of care for their particular needs. We want to ensure that FEHB subscribers are afforded high-quality patient care in the most cost-effective manner possible. This entails assuring that all services are medically necessary, safe, at the correct level of care and provided at the appropriate facility.

We hope to be innovative and receptive to new ideas and suggestions on ways to keep costs under control and still provide the needed health care services. We plan to look to the private sector and other Government health care Programs for input and confer with our contractors and other informed sources on new cost cutting approaches with potential applicability to our Program.

14. How will the reform measure more clearly fit the health care needs of Federal employees than the packages Federal employees now have?

Response #14

In discussing the current Program and the need for reform with enrollees around the country over the last year and a half, we were convinced that most of them wanted a simpler Program with fewer options. This was confirmed in the recent survey of employees, annuitants and survivor annuitants. They are confused and irritated by the number of plans currently available to them, all of which have similar benefits but at varying prices. Employees and retirees alike feel they are subsidizing the other and paying for benefits for which they have no need.

Our recommendations for reform recognize that employees and retirees have different health care needs. Therefore, we have proposed to establish two separate risk pools. Under this arrangement, benefits can be tailored to that particular group's needs and rates established to ensure that each enrollee within that risk pool pays the same premium for the same benefits package. Employees and retirees will have a measure of choice in deciding the level of health care coverage they need and the system of health care delivery with which they feel most comfortable. However, the choice will be limited and real -- not the panorama of look-alike plans with similar benefits and slight nuances in coverage and dramatic differences in premiums.

As I noted earlier, the Task Force on Federal Employee Health Benefits established within the DPC's Health Policy Working Group will play a key role in reviewing proposed health benefit packages for Federal employees in the future.

15. Will closed employee organization plans, e.g. SAMBA, Foreign Service, CIA, and BASE, still be permitted to offer their own plans?

Response #15

We have made no specific provision in our recommendations for reform for the continuation of any of the health plans offered by these employee organizations. However, having two risk pools where employees and retirees no longer subsidize each other allows us the opportunity to consider such questions. As a general observation, we believe it would be advantageous for all eligible employees to participate in the health insurance plans sponsored and administered by the Government. The advantages to the employees will be even more evident under the reformed FEHB Program. However, there may be a limited role for employee organizations under the reformed Program to provide some form of health benefits coverage for their own dues paying membership and their retirees, such as the offering of supplemental plans. Moreover, there may be compelling security reasons for organizations like the CIA to offer their own health insurance plans and we are open to discussing some distinct form of health benefits coverage for their employees and retirees.

16. There are seven independent U.S. Government agencies that currently offer health plans other than those offered under FEHBP. How does OPM treat alternative plans under the comprehensive reform proposal?

Response #16

In keeping with our general observation stated above, we believe it would be in the best interests of all concerned to have all eligible employees participating in the one group health insurance Program sponsored and administered by the Government. Although we did not specifically address the independent Government agencies that currently offer "alternative" health plans, strictly from a standpoint of Program equity, we would prefer that such agencies be required in the future to offer only their own health plans or FEHB participation -- not both -- as is the current practice.

Currently, a number of independent agencies offer both alternative plans and FEHB enrollments to their employees. They can offer these relatively young employees an attractive health insurance plan by virtue of their age and class of risk. However, participation in these alternative plans does not count toward the requisite five years of FEHB coverage prior to retirement needed to retain an FEHB enrollment during retirement, thus causing problems for many former employees. Whether these independent agencies extend coverage to their retirees and, if so, under what conditions/premiums is unclear. However, at a minimum, if these independent agencies are permitted to continue offering alternative plans, the extent to which they should be required to provide comparable coverage for their retirees will be addressed.

17. What will the premium categories be under the reform package? Will they remain the same as under the current Program?

Response #17

Under the current Program, there are two enrollment categories, self only and self and family. Until we gain some experience with the reformed Program, we would prefer to stay with those two enrollment categories. However, we would like the flexibility in the law to establish other categories of enrollment should they prove to be desirable. In the future, we would like the authority to establish additional enrollment categories based on family composition, such as couples or single parents if it would be administratively feasible and equitable.

18. Your February 7 letter stated that OPM's proposal was delayed because it needed "...to be consonant with broader administration health policy positions." Does the proposal which you submitted to me on March 1 have the Administration's full support and would this proposal be considered a model health insurance proposal for the private sector?

Response #18

My letter of February 7 stated that our proposal for FEHB reform needed to be consonant with broader administration health policy positions and reviewed for full Administration support. I am pleased to respond to you that the structure of our recommendations of March 1 enjoys the full support of the Administration.

In developing our approach to reform of the FEHB Program, we recognized that because of the size, the complexity, the mix of employees and retirees, unions, Government, insurance carriers, underwriters, legislation, etc., we had a set of rather unique problems to work with vis-a-vis the FEHB Program. I don't believe you would find such a unique set of circumstances/impediments to change on such a large scale anywhere in the private sector. Therefore, our overriding concern was the reform of this one health benefits Program, albeit the largest of its kind in the country, rather than the broader challenge of developing a model for the rest of the country.

The President has committed his administration to reviewing "the quality, accessibility and cost of our nation's health care system. [The President is] committed to bringing the staggering costs of health care under control." The DPC and the Administration, while not viewing this reform structure for the FEHB Program as a solution for the country, did not find anything in the proposal to negate their efforts for reform set against the larger backdrop of the nation's health care system in general.

19. How would OPM adjust the HMO rates to provide "appropriate" cross-subsidies between the indemnity plans and HMO plans? Does this mean that rates will be established on a geographical basis? What data exists today to support such cross-subsidy calculations?

Response #19

Each HMO's premium would be adjusted to reflect the age, sex, and family size of the HMO enrollees. These adjustments would be based upon actual Program data gathered by OPM actuaries. Since it is expected that in most cases the composition of the HMO's enrollment will consist of lower utilizers, the Government's contribution could be reduced to provide the appropriate cross-subsidy or alternatively there could be a premium loading to create a flow of funds to the indemnity plans.

OPM maintains a data base which contains the age and sex of enrollees by plan in which they are enrolled.

20. The OPM proposal states that, under its administrative authority, steps will be taken to assure that "...proper coordination takes place with respect to Medicare benefits and that payments do not exceed the specified maximum allowable actual charges." Please explain in detail how this portion of the proposal would be implemented and how it will work in practice. Please provide examples of benefit payments under the current

Program and how such payments will differ under OPM's administrative actions. In these examples, please demonstrate the effect on both Medicare and non-Medicare enrollees.

Response #20

In 1991, the maximum allowable actual charge (MAAC) will be set at 125 percent of the Medicare fee schedule. Under the current system, the usual, customary, and reasonable (UCR) amount paid by a plan in the FEHB Program is often higher than the MAAC. The following example illustrates such a situation for Medicare enrollees currently, and after OPM's administrative action is taken.

	Currently	Application of MAAC
Actual Charge:	$150	$150
Medicare Approved Charge:	$100	$100
Plan UCR:	$130	$130
MAAC:		$125
Medicare Pays:	$80 (.8x$100)	$80(.8x$100)
Plan Pays:	$50 ($130 - $80)	$45 ($125 - $80)

As you can see, the amount paid by the FEHB Program decreases from $50 to $45.

The Medicare enrollee would pay nothing out of pocket because the physician is prohibited from billing for more than the balance between the $80 that Medicare pays and the $125 MAAC.

For a non-Medicare enrollee, the FEHBP payment would not change under this administrative proposal. Our Program would continue to pay a coinsurance percentage of the UCR. The enrollee is responsible for the remaining coinsurance amount. As is the case today, no guarantee exists that the physician will not continue to bill the enrollee for the difference between the UCR and his or her charges.

The plans would be notified of the new provisions, and would coordinate benefits with Medicare, as they do now. Audits would be performed periodically to check compliance.

21. The OPM proposal would create five indemnity plans for federal workers. What are the largest indemnity plans in the current Program, and what is the total combined

enrollment? How would these five new plans differ from the current plans in terms of total enrollment?

Response #21

The five largest indemnity plans in descending order of enrollment are Blue Cross/Blue Shield, Mailhandlers, GEHA, NALC and APWU. Approximately 3 million enrollees are covered by indemnity plans Program-wide (approximately 75% of all enrolees) with nearly 2.8 million (91 percent) enrolled in the five largest plans. We have not developed any models to predict what type of plan individuals might elect under a reformed Program; however, it would appear reasonable to assume that current enrollees in indemnity plans would continue to elect that type of health plan arrangement.

22. Would you estimate the number and describe the demographic characteristics of those who would be included in each of the five indemnity plans and the HMOs?

Response #22

The following display presents the number and demographic characteristics of enrollees between the indemnity and HMO plans under the current Program. As stated above, we have not attempted to predict any movement among the various plan options for our proposal.

	Idemnity plans	HMOs
Enrollment	3,042,000	993,000
Percent - Male	64%	61%
Female	36%	39%
Age		
25	34,592	31,712
25-34	353,474	238,097
35-44	558,163	292,386
45-54	483,904	171,990
55-64	638,936	151,757
65-74	641,211	82,193
75-84	289,100	22,691
_85	42,530	2,565

23. Would you provide the specifications for the five options? Will there be a core plan? What benefits will be included in the "Hospital" and "Physician" plans? How many supplemental plans will there be? Does the

government pay part of the supplemental plan premium? Attached are the current specifications for Blue Cross-Blue Shield and GEHA. Please fill out the attached sheets, indicating any changes you will make from these current specifications.

Response #23

As I noted in an earlier response, we have concentrated thus far more on the structure of a reformed Program than on the specifics of the proposed benefits and the premium rate distribution between subscribers and the Government. Generally speaking, we envisioned four of the five indemnity packages being designed to respond to differing needs for inpatient and outpatient care with various levels of coverage for each. The fifth package might focus solely on supplemental benefits which the subscriber could purchase, without a Government contribution, to add to the basic coverage or to supplement coverage he or she might have outside the Government. We simply haven't developed our proposal to the point where we are ready to present particular benefits packages which would be available under the reformed Program.

24. Would you provide the specifications of the standard or minimum HMO plans, particularly the benefits for mental health, substance abuse, and prescription drugs?

Response #24

As noted above, we do not have the specifics you are seeking. However, we can assure you that the benefit levels for HMOs would be at least comparable to the average benefit levels provided Federal employees and retirees under the indemnity plan.

25. Would you provide the specifications of the retiree plans, that is, the Medigap plan and the Medicare" shadow" plan for those retirees not yet eligible for Medicare?

Response #25

Under our recommendations for reform, we would provide participants in the retiree risk pool the opportunity to enjoy a level of benefits equivalent to full Medicare coverage plus a Medigap policy. The Medigap policy would fill in the co-payments and deductibles not covered by Medicare, permitting full payment of charges up to Medicare's approved amount. The Medigap policy would meet the National Association of Insurance

Commissioners Guidelines for such policies and would be flexible to adapt to improvement changes in Medicare and Medigap policies. Retirees who have not yet attained age 65 and those individuals age 65 and over who either have no Medicare eligibility or do not wish to participate in the Medicare Program will be provided the same level of coverage as described above.

26. What are your government and employee/annuitant premium estimates for the various options?

Response #26

We have not developed any preferred benefits package(s) for employees/annuitants thus far and, therefore, have not prepared any detailed cost estimates. However, we do not expect any particular sub-set of the FEHB population to pay substantially more out of pocket for premiums than what they are paying currently. With enhanced cost containment, tighter management, elimination of State premium taxes, and use of the Medicare payment limits, we are hopeful that some groups of retirees may experience a reduction in out-of-pocket premium expense under our reform proposal.

27. S. 1048, "The Federal Employees Health Care Freedom-of-Choice Act," is pending in the Subcommittee. It requires the FEHBP fee-for-service plans to reimburse the full range of allied health providers. Does OPM's reform proposal provide for expanded access to providers?

Response #27

Our reform proposal does not specifically address the providers of health care services or how they would be recognized for payment purposes under a reformed Program. Traditionally, we have taken the position that we should not mandate the recognition of particular providers or health care practitioners through the Government or the FEHB Program.

We believe that issue, its costs and implications, could be explored after the structure of FEHB has been determined and implemented.

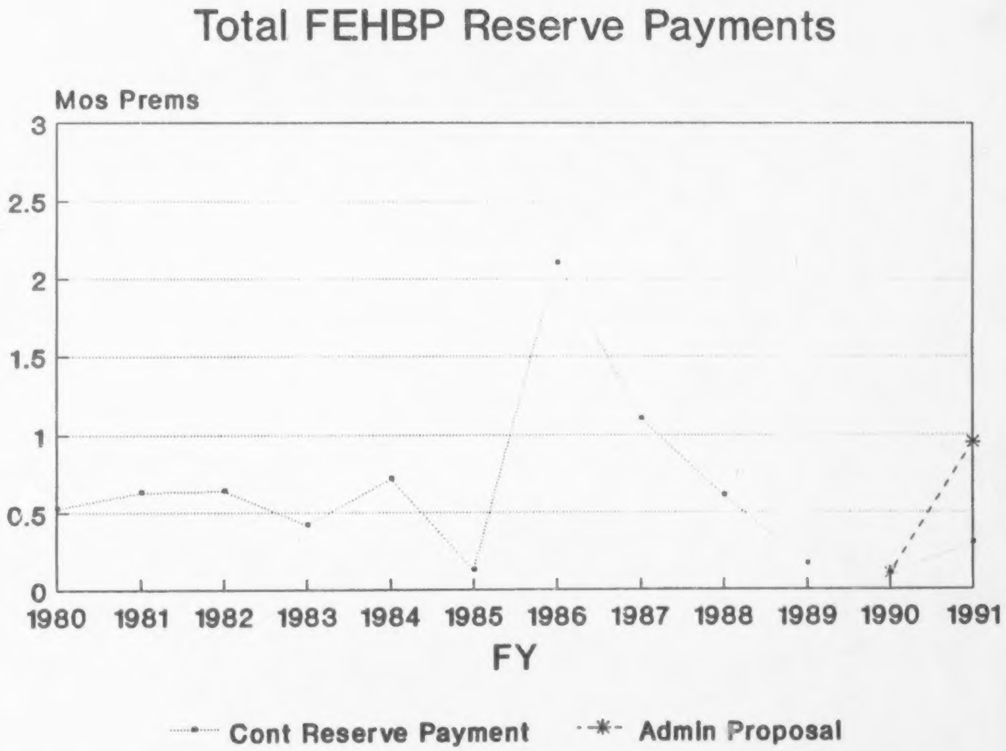
Attachment A

Summary of Employee Indemnity Plans

		Enrollee Pays		
		Blue Cross/ Blue Shield Standard	GEHA	Mailhandler High
Inpatient Care	Hospital	$100 deductible per admission	Nothing for R&B $250 deductible and 20% coinsurance for other	$125 deductible per admission
	Surgical, Medical	$250 deductible and 25% coinsurance	$250 deductible and 20% coinsurance	Amount above schedule*
	Mental Conditions/ Substance Abuse	$100 deductible and 40% coinsurance for unlimited days	$500 deductible and 50% coinsurance for care $250 deductible and amount above schedule for physicians visits	$125 deductible per admission, amount above schedule, amount above $2,500 but below $5,000 catastrophic limit
Outpatient Care	Hospital, Surgical, Medical	$250 deductible and 25% coinsurance	$250 deductible and 15% coinsurance	Amount above schedule* Amount above $26 per office visit
	Mental Conditions/ Substance Abuse	$250 deductible and 40% coinsurance for 25 visits plus visits over 25	$250 deductible and amounts above schedule plus visits over 30	Amount above schedule plus visits over 50
Prescription Drugs		$250 deductible and 25% coinsurance	$250 deductible and 15% coinsurance $9 mailorder copay	$300 deductible and 50% coinsurance
Dental		Amount above schedule	Amount above schedule	Amount above schedule plus amount above $800
Average Monthly Premium Per Enrollee	Currently Self Family $40.73 $77.64	Self Family $32.72 $68.77	Self Family $38.60 $73.00	Self Family $23.74 $61.31

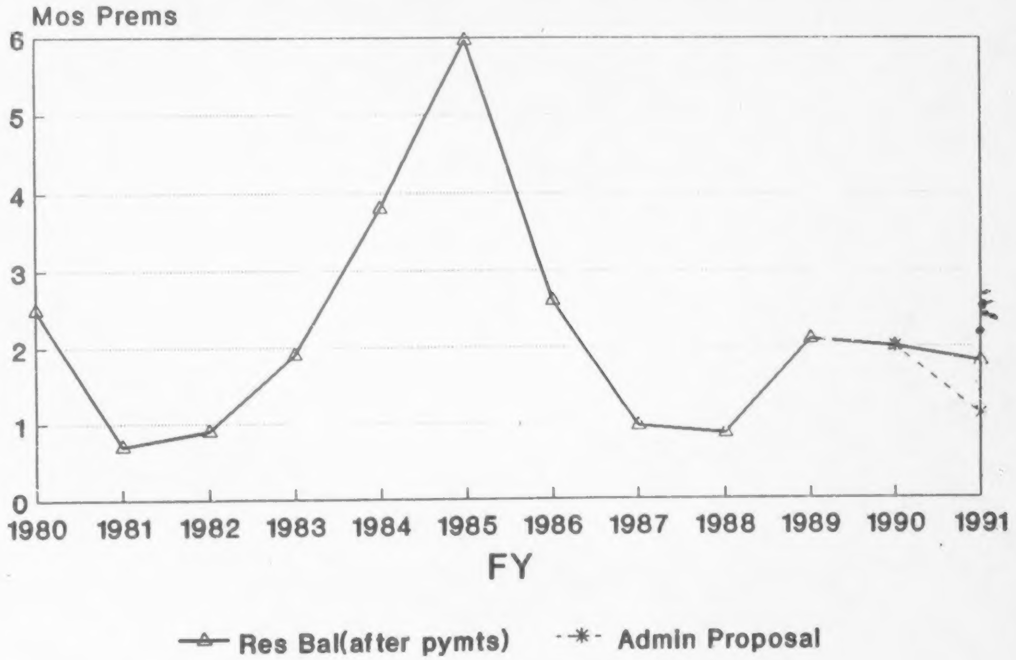
*Estimated to average 30-35% coinsurance

Attachment B



Attachment B

Total FEHBP Reserve Balances



Attachment C

FEHB Underwriter Losses

Losses by Underwriter and year:

CY	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	TOTAL
Mutual								($18,243,501)	($41,606,349)		($59,849,850)
Metropolitan								($2,519,228)	($9,674,790)		($12,194,018)
Prudential		($3,389,935)						($9,245,516)			($12,435,451)
	--------	--------	--------	--------	--------	--------	--------	--------	--------	--------	--------------
TOTAL:		($3,389,935)						($30,008,245)	($51,281,139)		($84,679,319)

	AFGE		Alliance		BACE		APWU		Foreign Service		GEBA		GEHA	
CY	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss
1978	Mutual		Mutual		-n/a-		none		Mutual		Mutual	*	none	
1979	Mutual		Mutual		-n/a-		none		Mutual		Pru.		none	
1980	Mutual		Mutual		-n/a-		none		Mutual		Pru.		none	
1981	Mutual		Mutual		-n/a-		none		Mutual		Pru.	($3,389,935)	none	
1982	Mutual		Mutual		-n/a-		none		Mutual		Met.		none	
1983	Mutual		Mutual		-n/a-		none		Mutual		Met.		none	
1984	Mutual	no loss	Mutual		-n/a-		none		Mutual		Met.		none	
1985	ULICO		Mutual		-n/a-		none		Mutual		Met.		none	
1986	ULICO		Mutual		Mutual		none		Mutual		Met.		none	
1987	ULICO		Mutual		Mutual	($86,019)	none		Mutual		Met. **	($2,519,228)	none	
1988	ULICO		Mutual*	($21,175,096)	Pru.		none		Mutual		CAC		none	
1989	ULICO		BCBSNCA		Pru.	*	none		Mutual		CAC		none	
1990	ULICO		BCBSNCA		BCBSNCA		none		Mutual		CAC		none	

* Final Actg. Statement not yet accepted.

* Data not available.

* Data not available.
** Final Actg. Statement not yet accepted.

	NAGE		NFFE		NTEU		Panama Canal		Postal Supervisors		Postmasters		Rural	
CY	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss
1978	-n/a-		-n/a-		-n/a-		Mutual		-n/a-		CAC	*	Mutual	
1979	-n/a-		-n/a-		-n/a-		Mutual		-n/a-		Pru.		Mutual	
1980	Met.		Pru.		Pru.		Mutual		Mutual		Pru.		Mutual	
1981	Met.		Pru.		Pru.		Mutual		Mutual		Pru.		Mutual	
1982	Met.		Pru.		Pru.		Mutual		Mutual		Pru.		Mutual	
1983	Met.		Pru.		Pru.	no loss	Mutual		Mutual		Pru.		Mutual	
1984	Met.	no loss	Pru.	no loss	Mutual		Mutual		Mutual		Pru.		Mutual	
1985	Mutual		Mutual	no loss	Mutual		Mutual		Mutual		Pru.		Mutual	
1986	Mutual		Pru.		Mutual		Mutual		Mutual		Pru.		Mutual	
1987	Mutual	**($18,157,482)	Pru.	($3,263,310)	Mutual		Mutual		Mutual		Pru. **	($5,982,206)	Mutual	
1988	ULICO		CAC		Mutual*	no loss	Mutual		Mutual	($17,840,932)	CAC		Mutual	
1989	ULICO		CAC		BCBSNCA		Mutual	**	CAC		CAC		Mutual	
1990	ULICO		CAC		BCBSNCA		Pan-Am.		CAC		CAC		Mutual	

**Final disposition in dispute.

** Data not available.

*Final Actg. Statement not yet accepted.

* Data not available
** Final disposition in dispute.

	NAPUS		Federal Managers		ACT		NATA		NALC		PATCO		Secret Service	
CY	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss	Underwriter	Loss
1978	-n/a-		-n/a-		-n/a-		-n/a-		none		-n/a-		-n/a-	
1979	-n/a-		-n/a-		-n/a-		-n/a-		none		-n/a-		-n/a-	
1980	GHI		-n/a-		-n/a-		-n/a-		none		Pru		-n/a-	
1981	GHI		-n/a-		-n/a-		-n/a-		none		Pru	no loss	-n/a-	
1982	GHI		-n/a-		-n/a-		-n/a-		none		-n/a-		-n/a-	
1983	GHI		-n/a-		-n/a-		-n/a-		none		-n/a-		-n/a-	
1984	GHI		-n/a-		-n/a-		-n/a-		none		-n/a-		-n/a-	
1985	GHI	no loss	-n/a-		-n/a-		-n/a-		none		-n/a-		-n/a-	
1986	Met		Mutual		-n/a-		-n/a-		none		-n/a-		-n/a-	
1987	Met		Mutual		CAC		Mutual		none		-n/a-		BCBSNCA	
1988	Met	* ($9,674,790)	Mutual	($2,366,000)	CAC		Mutual	($224,331)	none		-n/a-		BCBSNCA	
1989	BCBSNCA		(Discontinued)		CAC	**	(Discontinued)		none		-n/a-		BCBSNCA	
1990	BCBSNCA		-n/a-		n/a		-n/a-		none		-n/a-		BCBSNCA	

* Final disposition is in dispute.

** Data not available.

	SAMBA		Mail Handlers	
CY	Underwriter	Loss	Underwriter	Loss
1978	Pru.		CAC	
1979	Pru.		CAC	
1980	Pru.		CAC	
1981	Pru.		CAC	
1982	Pru.		CAC	
1983	Pru.		CAC	
1984	Pru.		CAC	
1985	Pru.		CAC	
1986	Pru.		CAC	
1987	Pru.		CAC	
1988	Pru.		CAC	
1989	Pru.		CAC	
1990	Pru.		CAC	

GHI - Group Hospitalization, Inc.
(aka,BCBSNCA)
CAC - Continental Assurance Company
Mutual - Mutual of Omaha Insurance Company
Met - Metropolitan Life Insurance Company

Pru - Prudential Insurance Company of America
ULICO - Union Labor Life Insurance Company
BCBSNCA - Blue Cross and Blue Shield of the National Capital Area
(formerly, GHI)
Pan Am - Pan-American Life Insurance Company

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

JUN 5 1990

Honorable David Pryor
Chairman, Subcommittee on Federal
  Services, Post Office and Civil Service
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Pryor:

This is in regard to your request for additional information concerning our recommendations for reforming the Federal Employees Health Benefits Program. My responses to the specific follow-up questions raised in your letter of April 25 are enclosed.

I appreciate the opportunity you provided to appear before your Subcommittee and trust that the responses I have provided to the questions you and Senator Wilson have since raised will sufficiently address the concerns you have expressed.

Sincerely,

Constance Berry Newman
Director

Enclosure

1. I am troubled that the focus of the OPM reform plan seems to be on the structure of the program and not on the benefits to be provided. While we are all aware of the fiscal realities, your proposal seems like building a house without providing windows or electricity. Why can't we have more details about the benefits OPM intends to provide?

Response #1

The chart which accompanied my letter to you of April 4 described various benefit packages to illustrate what may be possible under a reformed program. However, we do not have a preferred benefits package at this time. Any number of benefits packages can be addressed once we have decided upon the basic structure the Program needs.

The Domestic Policy Council's Task Force on Federal Employees Health Benefits is looking at design structures in the private sector to identify those that have shown some success in holding down health care costs and in improving the quality of care in circumstances analogous to those of the FEHB Program. In addition, we hope to be able to draw upon experiences in both the public and the private sector in crafting a benefit design for the FEHB Program that will be state-of-the-art administratively at the beginning of reform and flexible enough to remain that way as changes occur in the health care industry.

2. Have you had discussions with the Postal Service concerning their interest in creating a separate health insurance plan for only their active employees and future retirees? Are you coordinating your reform proposal with them?

Response #2

We have had discussions with the Postal Service about their interest in creating a separate health insurance program, and we have designed our recommendations for reform of the FEHB Program with the possibility of the withdrawal of the Postal Service in mind. We recognized early on that since the enactment of the Postal Reorganization Act in 1970, the Postal Service has had the legislative authority to offer their own health benefits program. We also recognized that it places the Postal Service in an awkward position in their negotiations with the unions to be responsible for a negotiated share of the cost of a health benefits program for more than 800,000 employees and their dependents but to have no say in the administration of the program.

The prospect of the withdrawal of the Postal Service, or other events which could alter the ratio of employees to annuitants in the FEHB Program, was one of the factors which prompted the creation of separate risk pools for employees and annuitants. Separate risk pools insulate both groups from destabilizing events, such as changes in group size. Had a single risk pool been proposed, the withdrawal of the Postal Service would have dictated a cost increase for the remaining enrollees as there would be fewer employee enrollees to help support a constant number of retirees.

The timing of any new USPS program needs to be carefully coordinated with the reform of the FEHB Program. The Postal Service is sensitive to this and will work with us to effect a smooth transition.

3. What is the Administration's position on the possibility of the Postal Service leaving only their current retirees in the FEHBP system?

Response #3

We understand that the Postal Service expects to cover future retirees, i.e., employees who retire on or after the effective date of a separate USPS health benefits program. We also realize that the USPS does not wish to cover current retirees under their new program. It is our position that the USPS should accept the financial responsibility for their retirees and survivor annuitants added to the annuity rolls since 1970 -- when the Postal Reorganization Act was passed. Even though we are proposing separate risk pools for employees and annuitants, it is important to bear in mind that annuitants, as a group, use more health care services, which translates into higher program costs. Thus, we believe the USPS should pay its share of these costs.

4. OPM's reform proposal suggests the establishment of two indemnity-type plans with two benefit levels within each plan. Each would focus on a different mix of benefits. How would this type of structuring avoid the problem of risk segmentation better than a reformed FEHBP with one core plan in which most employees and retirees participated?

Response #4

Risk segmentation occurs when the structure of a health benefits program permits enrollees with similar utilization characteristics, high or low, to congregate in plans and options whose premiums become disproportionately affected by the profile of the group attracted, as opposed to the actuarial value of the benefits for a more normative group of enrollees. The structure proposed by OPM addresses risk segmentation in a variety of ways. Two risk pools, employees and annuitants, are proposed so that differences in these groups can be explicitly recognized and managed. Second, demographic adjustments can be made to counter any risk segmentation which occurs between indemnity and comprehensive plans. Finally, while we believe that a reasonable element of meaningful choice should be maintained with respect to the indemnity component of the program, the specific benefit designs would be structured to mitigate against risk segmentation. Notwithstanding carefully designed indemnity benefit packages, self insurance permits appropriate price adjustments to be made among indemnity packages to account for any risk segmentation which might occur among them.

5. In your April 4 response, you said that retirees covered by Medicare plus the Medigap policy will get "full payment of charges up to Medicare's approved amount." But retirees covered by a FEHBP plan and Medicare now get 100% coverage of all expenses even if they exceed Medicare limits. Doesn't this mean that annuitants will be getting a cut in their benefit coverage?

Response #5

As you know, Medicare pays for physicians' services on the basis of "reasonable charges." Medicare currently pays 80 percent of the reasonable charge after the beneficiary has met the $75 annual deductible. In the case of assignments, the physician bills Medicare directly and agrees not to charge the beneficiary more than the applicable deductible and the 20 percent coinsurance. A participating physician is one who voluntarily agrees with HHS to accept assignments for the forthcoming year. Non-participating physicians have no such agreements with HHS and claims for their services are paid at approximately 95% of the rate established for participating physicians.

Retirees covered by an FEHB plan and Medicare now get 100% payment of Medicare's approved charge if a participating physician is used or 100% payment of the FEHB plan's usual, customary, and reasonable (UCR) amount if a non-participating physician is used.

Under the current system, the UCR amount paid by an FEHB plan is usually higher than Medicare's approved charge but less than the amount billed by the physician. Therefore, when non-participating physicians are used, the FEHB subscriber may still have an amount to pay out of pocket, i.e., the difference between the FEHB plan's

UCR amount and the billed charge. Essentially, this would not change under our reform proposal.

6. Currently, Medicare eligible retirees participating in FEHBP are 100% covered. Whatever Medicare does not reimburse (deductible, co-payments, drugs) is paid by FEHBP. Will these retirees in the new OPM proposal continue to receive the same 100% coverage?

Response #6

Under our recommendations for reform, retirees would have the combined benefits available under Medicare and a Medicare supplemental policy. The Medicare supplemental policy would cover such items as the Medicare deductible and co-insurance and a prescription drug benefit comparable to that which would be made available to employees.

7. Is OPM considering using the nine million participants of FEHBP to leverage the program's purchasing power? For example, will you try to negotiate with the pharmaceutical companies to obtain competitive drug prices?

Response #7

We are currently discussing with the Domestic Policy Council's Task Force on Federal Employees Health Benefits various ways in which we might be able to use the size of the Federal group to negotiate and/or leverage the best possible benefits and prices for our subscribers. This might be evidenced in the delivery systems of the Program itself, such as through preferred provider arrangements, HMOs, triple options, or networks of providers, or through discounts negotiated in the contracting process by our agents, the Third Party Administrators (TPAs). In any event, we will certainly be exploring all avenues available to us to maximize the potential for savings or benefit enhancements because of the size of the group we represent.

8. I understand that employees are seeking insurance with comprehensive dental benefits. Why hasn't OPM allowed FEHBP to improve the dental benefits? Will this be addressed under FEHB reform?

Response #8

In order to keep premium increases to a minimum, we have found it necessary for the last several years to reject proposals from FEHB Program carriers seeking to increase the level of dental benefits they provide. As we have stated earlier, there are any number of benefit and rate combinations that can be worked out once the structure of the reformed Program is decided. Certainly, there could be a benefits package designed to include enhanced dental benefits if there is strong support for such benefits and the costs associated with such benefits are clearly recognized. Enhanced dental benefits are a likely component for supplemental coverage.

9. During the past several years, there have been dramatic increases in health insurance payouts in the private sector. Has FEHBP had the same experience? If so, what will be done to contain these costs? If not, why have FEHBP's experiences been different?

Response #9

We have had about the same experience as you would find in the private sector. The Congressional Research Service noted in its report to Congress last May: "Although in recent years FEHBP premiums have increased dramatically, the rate of increase in average FEHBP premiums through the 1980s is similar to the growth in premiums in private sector plans. During each of the last three years, FEHBP premiums have increased on average by 20 percent. Over the last 9 years, FEHBP premiums have grown by an average of 12 percent annually." [House Committee Print 101-5, p. 18]

With regard to cost containment, our initial reform recommendations contained numerous proposals which should prove to be cost-effective from a program management standpoint, e.g. self insurance, the use of TPAs, etc. In addition, we are currently looking into more fully implementing such standard cost containment measures as pre-admission certification and large-case management as well as new and innovative measures that might be in place in the private sector and have proven to be (or appear to be) cost-effective.

10. Will FEHBP provide mental health benefits similar to the private sector under the standard plan outlined in your reform proposal?

Response #10

The benefits for mental health following reform should be comparable to what they are in the current Program. Benefits can and do change frequently in the private sector, and benefits for mental health are no exception. Some employers in the private sector have placed limits or substantial co-insurance/deductibles on their mental health benefits after recognizing the costs associated with the level of coverage they previously provided.

11. One of our witnesses will state that OPM has no system for correlating enrollments with agency premium contributions and payroll deductions. Therefore, many HMOs believe they have more Federal members than they receive payment for. Is OPM aware of this "reconciliation" problem and are you working on a solution?

    Do you have a data base system now in place which keeps track of this information? If not, how does OPM plan to handle the additional responsibilities it would assume if the Government moves to self-insurance?

Response #11

We are aware that certain HMOs have experienced problems in reconciling enrollment data reported by agencies and the actual premiums transferred by OPM; however, we do not believe there is a widespread problem in this area. As stated within the Federal Personnel Manual, it is the carrier's responsibility to initiate reconciliations. Since agencies maintain the enrollment information for individual employees as part of their payroll/personnel functions, responsibility for reacting to a carrier's request to reconcile rests with the agency payroll offices. OPM provides the carriers with detailed instructions on how to conduct reconciliations with agency payroll offices. In instances where unresolved discrepancies come to the attention of OPM, we work closely with the agencies and the carriers to assist in reconciling the differences.

We do not envision that an alternative enrollment collection process will be necessitated should we move to self-insurance; however, we will insist that participating carriers assume an aggressive role in maintaining accurate record-keeping systems.

12. What is OPM doing in the area of provider fraud detection? Are you encouraging carriers to develop fraud detection programs?

Response #12

We have had an ongoing audit program of carrier functions for many years, which has given us and the carriers some insight as to objectionable practices on the part of providers we would both want to investigate and pursue, e.g., unbundling of charges for diagnostic tests and services, using the wrong codes to upgrade the level of services provided and thus the payments they are seeking from the carriers, etc. Public Law 100-654 enacted in November 1988 gives us the authority to impose sanctions on providers for various offenses committed against the FEHB Program. The proposed FY 1991 budget for OPM's Office of the Inspector General includes a 33% increase in staff, which will improve fraud detection through more frequent on-site audits of carriers. We also will be working with the carriers to develop effective fraud detection programs and reporting mechanisms.

13. It is my understanding that the OPM plan proposes to place all retirees in one risk pool and employees in another risk pool. What is the rationale for this approach? Will there be separate reserves for the retiree and active employee risk pools?

Response #13

You are correct that our reform initiative recommends separate risk pools for employees and retirees. In formulating our proposal, we gave considerable thought to other configurations, e.g., a single pool for all enrollees, and separate risk pools for active employees, those retirees with Medicare and those without. However, it appears that establishing two risk pools, one for employees and one for retirees, provides the maximum degree of equity for both general categories of participants concerned.

On its face, a single risk pool seems to make the most sense because it assembles the largest number of individuals for the purpose of spreading risk for insurance purposes. A single risk pool is also attractive because it is usually perceived as being equitable in its uniform treatment of participants. However, a single FEHB risk pool does not constitute a homogenous group, and this has a number of potentially adverse implications. In broad terms, the single risk pool would encompass two distinct subpopulations--employees and retirees, with the latter group potentially subdivided by Medicare eligibility. The relative proportions of these subpools will not be stable in the long term and, depending on the structure of the FEHB Program, possibly the short term. Moreover, given the opportunity to do so, the subpools will tend to segregate themselves into more homogenous groups as has been the case in the current Program. In recognition of this tendency and for more effective control of the Program, we believe the segmentation should be explicit, so that we can manage it.

With this two-risk-pool arrangement, employees would not bear the cost of subsidizing the non-Medicare retirees, and an attractive benefit package could be designed with employees' needs in mind. This option provides a clean and understandable change in benefit programs when one retires. The benefit package for all retirees would reflect a combination of Medicare benefits and Medigap benefits. Ideally, any retirees age 65 and over who are not insured for Medicare Part A based on their own, or a spouse's, employment would be afforded the opportunity to elect voluntary participation within a scheme allowing the FEHB Program to pay the Part A premium charge for uninsured aged individuals. The only differences in FEHB benefits for annuitants would be that, for retirees over age 65, all claims would go to Medicare first, and FEHB premiums otherwise specified for retirees would be reduced by the equivalent of the premium required of all Medicare Part B participants.

Under our proposal, all the retirees in the risk pool would pay a level premium for the retiree benefit package. This obviously represents a subsidy from the annuitants with Medicare to those under age 65 without Medicare. Each group of annuitants must recognize that, as they are being subsidized at an earlier age (pre-Medicare), they must, in turn, subsidize those that retire after them.

If we were to establish risk pools for employees, retirees with Medicare, and retirees without Medicare, the non-Medicare retirees would have no cross-subsidy from either of the other risk groups and would, therefore, be faced with extraordinarily high premiums due to their high rates of utilization. For premium-rating, the two proposed risk pools would be treated as separate entities. The reserves would be maintained in a single Treasury account, with sub-accounts established for the two risk pools.

14. The functions that Third Party Administrators would perform under OPM's proposal are vastly different from the functions now performed by insurance carriers. Yet, OPM maintains that existing staff can handle these different responsibilities. Please tell me who would negotiate with providers, for example, in Little Rock, Arkansas? Would OPM select the participating physicians? Will OPM negotiate discounts with particular hospitals?

Response #14

OPM will be designing the benefits, deciding on the appropriateness of suggested cost containment measures, and establishing standards for the Third Party Administrators (TPAs) to operate within. The TPAs will process claims, implement the cost containment measures we have agreed upon, and negotiate on our behalf with local providers to receive maximum discounts or price reductions vis-a-vis the provision of health care services. No specific number of TPAs has been decided upon, nor have the geographic areas of the country been clearly identified or numbered. However, the specific functions at a local level which you identified in your inquiry would be performed by the TPA serving that particular geographic area in the country -- not by OPM.

15. How does the Government save money by combining and reducing reserves to one month? Will the amount of reserves provide an actuarially sound cushion for future costs? If there are savings, can't you reduce the reserves of each carrier to one month under the present proposal and save the same amount of money?

Response #15

The current program has a reserve goal of two months of claims and expenses, which is set on a plan-by-plan, and option-by-option, basis. While experience tells us that this level of reserves is excessive for the overall program, there have been occasions when individual plans and options have exhausted their specific reserves. Thus, reserve unification is the only viable vehicle for reducing reserve levels (and premiums and Government costs) within the current structure of the FEHB Program.

16. Under OPM's 21 month contract term, how will such items as the "annual" deductible or co-pays be handled for the 9 month portion of the term? If the annual deductible has to be met in nine months, doesn't this constitute a significant benefit reduction? In any event, do the 12 month and 9 month segments have any actuarial effect?

Response #16

We do not intend to modify the FEHB Program's benefit provisions during the nine-month contract extension which is necessary to convert the Program to operating on a fiscal year basis. In some instances, e.g., number of dental visits or mental health and substance abuse visits covered, this constitutes a benefit increase, and in others, e.g., annual deductibles, a decrease. This policy does not constitute any shift in the costs borne by the Government vis-a-vis FEHBP enrollees, because the 1992 premiums will reflect the actual costs anticipated for the nine-month extension.

Senator Wilson's Questions

1. Do you believe that as the nation's largest employer, the federal government can serve as an example and catalyst to the private sector in the design of compensation strategies?

Response #1

Yes, the Federal government has a leadership role to play in designing compensation strategies that will work well for the Government as an employer and for the Nation at large. We are trying to set those examples, as evidenced in our recent pay reform proposal and in the development of this FEHB reform initiative.

2. Do you consider long-term care insurance to be a benefit that federal employees would find attractive?

Response #2

Federal employees who recognize the enormous costs associated with nursing home care and extended home care to assist in activities associated with daily living should recognize the benefit to be derived from long-term care coverage made available to them at group rates.

3. Generally speaking, in the context of FEHBP reform, do you envision the inclusion of long-term care insurance as a benefit option available to active and retired federal employees through a supplemental plan or plans? If not, why not?

Response #3

We would certainly want to consider making long-term care coverage available to our employees, perhaps as a freestanding supplement to the basic coverage. As you know, long-term care is an extremely expensive benefit. Most people now realize that neither Medicare nor typical group health insurance coverage will pay for such expenses. Whatever approach is used for making long-term care available to Federal employees and retirees, we will have to bear in mind the extraordinary costs associated with this benefit and ensure that long-range financing is guaranteed to keep the premium associated with such coverage affordable for the participants.

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

Honorable Dan Quayle
President of the Senate
Washington, DC 20510

Dear Mr. President:

It is my pleasure to submit to you my recommendations for comprehensive reform of the Federal Employees Health Benefits (FEHB) Program as required by Public Law 101-76. After a great deal of research and consultation, the Office of Personnel Management has developed recommendations on the basic design of a comprehensive reform proposal.

The discussion of our recommendations is organized as follows: I. Problems with the Current Program; II. The Need for Reform; III. A Statement of Goals and Reform Recommendations; and IV. Steps to Reform.

I. Problems with the Current Program

Major deficiencies of the FEHB Program were documented in a report prepared for OPM by Towers, Perrin, Forster and Crosby in April, 1988 and in a report prepared by the Congressional Research Service in May 1989. These reports identified a number of structural problems inherent in the current Program, stemming from two basic sources--risk segmentation and economic inefficiencies.

Risk Segmentation

Risk segmentation/risk selection occurs when individuals representing the same level of risk congregate in a given plan or option. The TPF&C Report found that the FEHB Program is a classic example of that phenomenon. Too many elderly and chronically ill participants have gravitated to certain plans or options while younger, healthier subscribers have clustered in less costly and sometimes less comprehensive health benefits plans. This isolates the people who need coverage the most in plans that many of them can ill afford.

The premiums of the plans are affected more by enrollee characteristics, especially age, than by the actuarial value of the benefits offered. In the case of Blue Cross/Blue Shield, both the high and standard options have approximately equivalent benefits from an actuarial standpoint but there is more than a fivefold difference in employee premium rates. Aetna was so impacted by risk segmentation, having retained so many elderly retirees, that its premiums were totally out of line with the actuarial value of the benefits offered when it determined that its plan was no longer viable and decided to withdraw from the Program.

Risk segmentation has also adversely affected the manner in which the Government contribution is set. The "Big Six" formula was devised in 1970 as a means of ensuring that the Government's contribution would be based on representative rates and enrollment levels. The high options of the two Government-wide plans, the two largest employee organization plans and the two largest HMOs were to be used. In 1974, the high options of the two Government-wide plans accounted for 65 percent of total FEHB Program enrollment. Today, only one of those two plans currently exists and accounts for less than 15 percent of total FEHB Program enrollment. However, the Government contribution is still greatly influenced by these non-representative high cost plans.

Economic Inefficiencies

Specific economic inefficiencies were reviewed in some detail in both the TPF&C Report and the Congressional Research Service Report. The absence of competition by plans for entry into and retention by the Program is an example. This leads to a considerable loss of leverage the Federal Government might have exercised in the selection of and negotiations with carriers. Too many plans with only subtle differences in benefits have been made available to subscribers. This has not only added to the confusion of subscribers in making health plan choices; it has multiplied the Government's costs and fragmented its buying power.

The self-renewing nature of FEHB Program contracts, together with the fact that gains and losses are carried forward into the subsequent year's premiums, insulates carriers from true financial risk. Yet, under the current law, the Government and FEHB Program enrollees still pay risk charges and profits, as well as state premium taxes and duplicative administrative expenses. In short, we are spending too many dollars on items that don't translate into actual health benefits or health care services.

The FEHB Program is currently burdened with too many carriers who enter the Program without true competition and remain in the Program indefinitely regardless of merit. The only competition is at the consumer level where it is difficult at best to make an informed choice. Employee organization plans have evolved into additional "Government-wide plans" and charge associate member dues for which no health care services are received. All employees, retirees with Medicare, and retirees without Medicare enrolled in the same plan pay the same premium -- raising questions of equity among these groups. The annual open season resembles a high stakes gambling event for all participants concerned.

II. The Need for Reform

It has been suggested that the current FEHB Program is somehow salvageable and can be made cost effective. Some would contend that risk segmentation is not necessarily bad because it is the high users of health benefits who pay the highest premiums. Every enrollee has an annual opportunity to modify his or her health benefits coverage. Others believe that risk segmentation will eventually become less of a problem as FEHB enrollees become better consumers and/or as the plan and options which are no longer viable from an insurance standpoint, such as Aetna, go out of business.

The aged, the ill, and the infirm should not pay more for insurance coverage that is essential to their well being simply because these individuals are not sufficiently informed and will not select more cost effective coverage. For whatever reason, those most in need of health care are among the least likely to modify their insurance coverage. Even after multiple notices about the plan's termination, over 10,000 elderly Aetna enrollees failed to make timely elections of new coverage. OPM ultimately took unilateral action to place such individuals in a new plan.

Even if OPM possessed the authority to do so, combining unviable plans and options with those that possess more favorable demographics would not cure the Program's ills. Healthy enrollees will continue to distance themselves from the ill and less mobile. An analysis of last year's open season changes revealed that enrollees leaving the Blue Cross Standard Option were lower users of health care than those who joined the option. This trend will be aggravated with the arrival of the displaced Aetna enrollees and could well be a precursor to the demise of the Blue Cross plan within the FEHB Program.

The problems of the FEHB Program are numerous and well documented. We have clearly reached the point for incisive action and resolution of those problems.

III. Statement of Goals and Reform Recommendations

The objectives of OPM's reform recommendations are to continue the principle of cost sharing and informed choice, and offer the best possible insurance coverage for Federal employees and retirees for the money expended. We have to be mindful of the problems experienced to date under the original FEHB Program and the rapidly changing state of the art in creating and administering an employer sponsored health benefits program. We also need to begin with a fiscal management concept that is sound but not inflexible.

The Program must be simpler in form for the participants to understand; it must be more efficient in terms of benefits for premium dollars; and it must be fair to all segments of the enrolled population. In short, FEHB reform should result in (1) an informed choice for Program participants, (2) equity for both employees and retirees, and (3) economic efficiency in the operation of plans benefiting both the enrollees and the Government. The resultant program should be one that prudently purchases quality health care services.

Informed Choice

Problem: There are too many plans with only subtle differences in benefits but tremendous differences in premiums.

Recommendations:

- Give enrollees a clear, understandable choice between (1) five indemnity packages with benefit structures designed to meet varying enrollee needs and with premiums set on a nationwide basis and (2) the HMO alternatives in a given geographic area.
- Require participating HMOs to offer a standard benefits package at a rate adequate to provide these basic benefits. OPM would adjust the HMO rates to provide appropriate cross subsidies between the indemnity plans and HMO plans. Competition between HMOs would be based on price, convenience, and service provided. HMOs would be permitted to offer supplemental packages.

Equity

Problem: Employees, retirees, and Medicare eligibles in a given plan all pay identical premiums. However, these groups actually receive significantly different benefits in return for their premium dollars. The benefits derived by these individuals are largely governed by the benefits of the plan they select during the annual open season and health and Medicare status during the year.

Recommendations:

- Create distinct risk pools for establishing benefits and rates--one for employees and another for retirees; neither subsidizes the other;
- Tailor benefits for each distinct risk pool based on the health insurance needs of that pool;
- In the retiree pool, offer those retirees with Medicare coverage a Medicare Supplemental Policy to fill in the gaps that Medicare does not cover;
- Give all retirees over age 65 who do not have such coverage the voluntary opportunity to buy into that program and to be covered by it and by the Medicare Supplemental Policy.

Economic Inefficiencies

Problem: Numerous indemnity plans now compete for market share, with contracts that renew automatically and which bear no risk. The plans tend to be inefficient in terms of administration and containment of health care costs. The number of such plans cause higher than necessary administrative expenses at the carrier and OPM level.

Recommendations:

- Create five indemnity benefit packages administered through contracts;
- Have the contractors process claims and administer effective cost containment measures such as pre-admission screening and case management;
- Self insure to eliminate state premium taxes and significant amounts in risk charges and duplicative carrier profits.

IV. Steps to Reform

The Administration proposes either to stabilize Government expenditures by using a weighted average formula for determining its contribution under the FEHB Program or to adopt a mix of legislative and administrative initiatives.

The "weighted average" formula would substitute, as a cap on the maximum dollar amount the Government would contribute to each employee's plan, 60 percent of the weighted average of all plans for 60 percent of the simple average of "Big Six" carriers. In 1975 when the "Bix Six" represented 90 percent of all FEHB program usage, the "Big Six" formula served as a useful proxy on which to base a cap on the Government's share of the program. Today, with 321 plans and Aetna (one of the "Bix Six") having decided to leave the FEHB Program, the "Big Six" program no longer reflects actual usage. The weighted average approach thus reflects better the original intent of the FEHB legislation.

The alternative mix of legislative and administrative initiatives would have the same beneficial impact on the budget for FY 1991. Required legislative actions would include the following: Immediate preemption of state premium taxes; unification of the contingency reserves which now exists on a plan by plan basis and are excessive in view of the risks confronting the Program as a whole; and changing the calculation of the FEHB Government contribution from 60 percent of the "Big Six" average to 67 percent of the weighted average, resulting in an aggregate Government share of premium costs of 65 percent.

The two alternative approaches would result in a Federal budget outlay pattern (in millions) as follows:

	FY 1991	1992	1993	1994	1995
Current services baseline outlays*	3,213	4,181	5,089	5,809	6,554
Weighting average proposal	-850	-1,210	-1,390	-1,598	-1,806
Mix of administrative and legislative initiatives	-850	-894	-1,061	-1,304	-1,595

*Represents outlays from OPM FEHB Fund and annuitant account; does not reflect agency FEHB expenses.

Required administrative actions that OPM would undertake under its own authority during the transition year would be consistent with the reform objectives and would lessen the rate of increase in enrollee premiums.

We would take steps to assure that proper coordination takes place with respect to Medicare benefits and that payments did not exceed the specified maximum allowable actual charges. We would also mandate that appropriate cost containment techniques are adopted by participating carriers and that independent assessments of the effectiveness of these techniques and Medicare coordination are reflected in the profit charges accorded to participants.

Once the reform structure is in place, we will seek the optimum in innovative approaches to containing health care costs, and institute state of the art concepts in benefits administration. For example, we plan to establish an experiment for an Administrative Disputes Resolution (ADR) process wherein an FEHB subscriber could submit a claim for damages against a health care provider for malpractice or bodily injury to binding arbitration rather than pursuing litigation. Such an experiment would probably be best suited initially to staff model HMOs and their enrollees. We also plan to work closely with our contractors to formulate innovative strategies to address such health related problems as smoking and negative life style habits. Conversely, we intend to make maximum use of early detection mechanisms and preventive services intervention that have proven clinical effectiveness.

These steps are part of the Administration's commitment to a thorough review of the quality, accessibility, and cost of our nation's health care system, and we will continue to refine our recommendation as part of this review. We are committed to helping the President bring the staggering costs of health care under control while providing the necessary health coverage. The Administration looks forward to working with the Congress to solve the very serious problems facing our health insurance program for Federal employees. We recognize that various proposals for FEHB reform will be considered in the coming months and that no one can be sure what form these changes might eventually take. However, it is imperative that whatever is finally enacted meet the FEHB budget savings included in the President's FY 1991 Budget for FY 1991 of $850 million.

The Office of Management and Budget advises that, from the standpoint of the Administration's program, there is no objection to the submission of this report.

Sincerely,

Constance Berry Newman
Director

Congressional Research Service
The Library of Congress

Washington, D.C. 20540

TESTIMONY OF THE FEDERAL EMPLOYEES HEALTH BENEFITS TEAM

Before Hearings of the
Subcommittee on Federal Services,
Post Office, and Civil Service
Committee on Governmental Affairs
U.S. Senate

April 20, 1990

TESTIMONY OF FEDERAL EMPLOYEES HEALTH BENEFITS TEAM

Good Morning, Mr. Chairman and Members of the Committee. The Federal Employees Health Benefits (FEHB) Team appreciates the opportunity to address the committee on the important subject of Federal employees health insurance. I am Dennis Snook, and with me today are some other members of the team, created to serve certain technical interests of the two committees as they review the program. To my right are Janet Lundy and Michael O'Grady of the Congressional Research Service (CRS). On my left are Alan Fairbank of the Congressional Budget Office (CBO) and Sheila Smythe of the General Accounting Office (GAO).

Mr. Chairman, the FEHB team thoroughly studied the Federal Employees Health Benefits program (FEHBP). We developed a methodology that allows us to compare the multitude of plans in the program to each other, to plans in the private sector, and to the approaches that might be used to reform the program. Details of the study can be found in our report, published by the Post Office and Civil Service Committee last May. I will briefly summarize our study findings, and other panelists will elaborate on specific areas.

The FEHBP will spend $12.5 billion paying for the benefits of over 9 million employees, annuitants, and dependents during FY 1990. The Federal Government will pay about $8.9 billion, or about 71 percent of this cost. The enrollees will pay the remaining 29 percent of the cost, an amount that averages about $906 per year per enrollee. Our study determined that the typical Federal worker receives about $1,100 a year less in employer-paid health benefits than the typical private-sector corporate counterpart. After accounting for demographic differences, we also found that the Federal population is no more expensive to insure than the general public.

During the annual open season, enrollees will choose from among nearly 400 plans with each individual able to select from as many as 36. This is an imperfect market. With the possible exception of health maintenance organizations (HMOs), the plans are not substantially at risk for the total costs of the benefits they offer, as each year gains and losses of the previous year are rolled over into subsequent premiums. Nor are plans rewarded for an especially efficient operation--profits and reimbursement for administrative expenses are strictly controlled.

Most critical examinations of the program usually focus on the problems created by the existence of choice: The Government, unlike other large employers, does not choose the level of coverage it wishes to provide and then select the most efficient form for providing that coverage. Instead, individuals choose from among a selection of plans that are relatively free to design benefits to appeal to enrollees. The result is that rational benefit design becomes complicated by marketing strategy.

This structure has led to three general problems: ***First***, the annual multiple choice among many plans is confusing because an adequately informed selection is nearly impossible to achieve; ***second***, the spread of participants across the array of plans has caused a distribution of the burdens and benefits of the program that contradicts both the ordinary expression of an insurance principle and the presumption that a program of public policy will provide similar treatment to individuals in similar circumstances; and ***third***, dissipation of a potential market force of more than 9 million people dilutes strength that could be harnessed to reduce Federal obligations for the program and, perhaps, to lead efforts to gain control of overall health care costs.

In short, the program is a complex dynamic between plans and participants. The primary purpose of the program--financial protection against medical costs--is confused, and its goal--avoiding unnecessary Federal expenditures--is uncertain. The people who do the best under the program are often either lucky, or they know the most about its dynamics. Those who are least advantaged are often the poorest, the oldest, the sickest.

The general issue confronting those interested in FEHB reform comes down to this: Does this array of choices work to the advantage of the enrollees, or are the actual benefit differences much less important than the demographic characteristics of the enrolled population? Does the competition for enrollees help to constrain costs, or does it make cost controls more difficult to implement? Would the Federal Government, including its employees, be better served if control of the program were more centralized, so that the relationship between benefits, enrollee payments, and Federal costs were a function of Federal policy, rather than the residue of the participants' own actions?

Mr. Chairman, before I turn to the other members of the panel, I would like to cite our general conclusion: Reform of the program could solve many of the serious problems. However, reform will not save the Government substantial sums unless it is coupled with benefit reductions, more cost-shifting to enrollees, or greater controls over providers.

With your permission, Mr. Chairman, other panelists will elaborate on certain of our findings, a copy of which we have submitted for the record.

Good morning, Mr. Chairman. My name is Michael O'Grady. Today I will discuss the effect that choice has on the FEHBP in terms of cost to the overall system and premiums to the enrollees. A common complaint is that choice has made the current system more expensive than need be. As Dr. Snook has pointed out, some market advantage may be lost by not taking full advantage of the purchasing power of 9 million people, but has choice itself increased costs? The answer is no.

In general, any program allowing people to choose between high and low option plans can lead to risk segmentation, which is the grouping of healthier people in some plans and sicker people in other plans. This risk segmentation, in turn, can cause some premiums to rise dramatically, but it does so without increasing overall costs. The following example illustrates this point:

Risk Segmentation and Its Effects on Premiums and Systemwide Costs

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Example: A High and a Low Option Plan in a Closed System

Year #1

High option		Low option	
# of enrollees	Costs per enrollee	# of enrollees	Costs per enrollee
10	$2,500	10	$1,500
10	$1,500	10	$ 500
Premium	$2,000		$1,000
Total costs	$40,000		$20,000

Total costs, both options together: $60,000

Year #2

High option		Low option	
# of enrollees	Costs per enrollee	# of enrollees	Costs per enrollee
10	$2,500	15	$1,500
5	$1,500	10	$ 500
Premium	$2,167		$1,100
Total costs	$32,500		$27,500

Total costs, both options together: $60,000

Effects on Enrollees:

15 enrollees went from paying $2,000 to paying $2,167 (+$2,500)
20 enrollees went from paying $1,000 to paying $1,100 (+$2,000)
5 enrollees went from paying $2,000 to paying $1,100 (-$4,500)

In this example, the high option plan has 10 enrollees with annual health care costs of $2,500 and another 10 enrollees with costs of $1,500 in year one. Excluding administrative and the additional costs, this would result in a premium of $2,000 for each enrollee and a total cost of $40,000.

By contrast, the low option plan has 10 enrollees with costs of $1,500 and another 10 with costs of $500, resulting in a premium of $1,000 and a total cost of $20,000. Total costs for both options is $60,000.

If in year two, five of the people with $1,500 in annual costs recognize the benefit of moving from the high option to the low option plan, the premiums in the high option will increase from $2,000 to $2,167 and the high option cost drops from $40,000 to $32,500. At the same time, premiums in the low option will rise from $1,000 to 1,100 and total costs will rise from $20,000 to $27,500.

As the table shows, the movement of a small number of people from the high option to the low option causes the premiums of both options to rise, but the total cost to the system remains at $60,000.

So far, we've examined the effect of choice on health plans in general. Now what effect does choice and the resulting risk segmentation specifically have on the Federal plan? It has caused wide variations in premiums among different plans, with the vast majority of the price difference being absorbed by enrollees.

The following chart illustrates this point by displaying the differences among fee-for-service plans under FEHBP in 1989. Three different distributions are shown here: (1) differences in the value of the benefits being offered, (2) differences in the premiums charged, and (3) differences in what the enrollees have to pay. While there are differences in the benefits offered by the different plans, CRS estimates that the most generous benefit package has a value that is about 46 percent greater than the least generous package. The premiums vary much more. The most expensive plan is 246 percent more expensive than the least expensive plan.

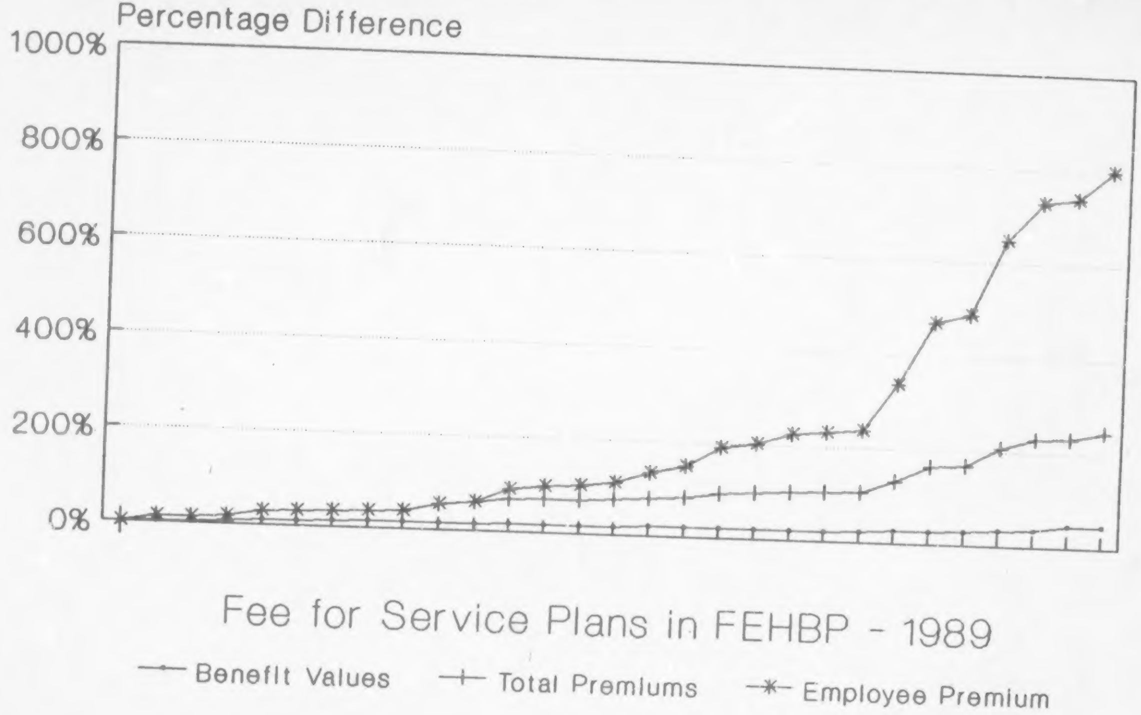
Why is there such a difference in price compared to the benefits offered? Risk segmentation. FEHBP is an extreme example of risk segmentation. Premiums differ widely among plans, not because of differences in the health benefits offered, but because of differences in the populations served. The concentration of very sick people in certain plans has driven their premiums up at much faster rates than other plans. Conversely, other plans that have been able to attract a younger, healthier population have been able to keep their premiums down.

This situation becomes even more extreme when the enrollees' premiums are examined. While the Government has suffered some increased costs from risk segmentation, due to the particular nature of the Big Six funding formula, the brunt of cost and gain from risk segmentation has been borne by the enrollees. The chart also displays the range of differences in what enrollees pay. In 1989, a non-postal enrollee could pay from $240 to $2,200 annually, or a difference of about 800 percent between the highest and lowest plans.

Conclusion

While there is limited variation in the benefits offered under FEHBP, there is wide variation in what different workers and retirees have to pay for health benefits. Any action to change this situation should be tempered with the knowledge that without either more Government money or substantially tighter controls on cost, any attempt to reduce the high end enrollee premiums will mean increased premiums for those currently at the low end.

Benefit Values, Total Premiums and Enrollee Premiums Among FFS Plans



CRS analysis based upon OPM data.

My name is Janet Lundy, and I will address three questions related to health plan costs and cost containment.

First, are FEHBP costs too high?

FEHBP's annual cost is estimated to be $12.5 billion for FY 1990, and it is the Nation's largest employer health plan. Over the past decade, FEHBP premiums have grown by an average of 12 percent annually; for some years increases have reached 25 percent. Although substantial, these increases are similar to the cost increases of large private-sector employer health plans.

Second, would adopting cost control measures save money?

As health care costs have risen, employers have sought to restrain this growth. While experience from the private sector suggests that cost controls save some money, considerable doubt exists that they can reduce costs substantially. Aside from relatively small savings that can be achieved through reductions in administrative costs, reducing health insurance costs requires changing the following:

- Reducing the amount of services used by enrollees,
- Controlling payments to the providers of services, or
- Increasing the enrollee's share of plan costs.

Let me elaborate on these three approaches.

Reducing the amount of services used by enrollees. Many employers believe that costs can be reduced by controlling utilization. Utilization controls, also known as managed care, include such measures as pre-admission certification for elective hospital stays, concurrent review of the length of hospital stay, and case management of care for high-cost patients.

FEHBP's HMOs use the managed care techniques adopted by most HMOs to control costs. Although not required by the Office of Personnel Management (OPM), some FEHBP fee-for-service plans also have incorporated certain utilization controls. But cost-saving approaches are not used throughout the program because some plan administrators think that adopting them will drive off enrollees. We understand that OPM's instructions for the 1991 program **require** participating plans to include certain cost containment proposals, including pre-certification and management of expensive cases. If such programs are mandatory, no plan should be at a competitive disadvantage.

Controlling payments to the providers of services. There are a number of ways to control costs by reforming payments to providers. However, unless providers are required or agree to accept the plan's payment as the full payment, these methods merely shift costs to enrollees.

One approach is to establish fixed payment amounts, as does Medicare's prospective hospital payment system. Another is to set maximums on payments to health care providers, such as the "reasonable and customary" limits used by most FEHBP fee-for-service plans. Although these limits may reduce plan costs, lack of information about the limits makes it difficult for enrollees to compare plan payments and the out-of-pocket costs they face as a result.

Another payment approach is for the employer or the employer's representative, such as a third-party administrator, to negotiate prices with providers. The Federal Government has been criticized for not using its large purchasing power to negotiate discounts or to require providers to accept its payment rules, as does the Medicare program. On a smaller scale, certain individual FEHBP fee-for-service plans are negotiating provider discounts for hospital and medical services through "preferred provider" programs. In addition, 2 of the 20 FEHBP fee-for-service plans have prescription drug card programs, where payments have been negotiated with participating pharmacies, and 14 plans have mail order prescription drug programs, through which long-term supplies of drugs can be purchased at discounted prices.

Increasing the enrollee's share of plan costs. In 1981, OPM required the FEHBP plans to include enrollee cost-sharing provisions such as deductibles and coinsurance. Since then, they have become a permanent feature of the fee-for-service plans. Many think that enrollee cost sharing is effective in helping to control utilization, though others think that cost sharing may discourage people from seeking needed care.

Third, would reform of the FEHBP structure save money?

As mentioned earlier, our study found that one of the program's major features, choice, has an insignificant impact on overall program costs. As we indicated in our report to Congress, major structural change to FEHBP could solve certain perceived problems, but would not save Federal funds unless it were coupled with benefit reductions, more cost shifting to participants, or controls on providers.

FINDINGS SUBMITTED FOR THE RECORD

As the Federal Employees Health Benefits program (FEHBP) nears the end of its third decade of operation, it is undergoing scrutiny because many believe that the program no longer effectively serves the interests of the Federal Government, or of its current and former employees and their dependents. The annual "open season," during which participants elect a plan for the following year, causes considerable anxiety for some people who sense the need to make an important decision about which they understand little. Many retirees believe that they are unfairly treated under the program, especially in light of recent changes to Medicare. Others affected by the program are concerned that premium increases are larger than necessary. Finally, some question whether the program's principal distinguishing characteristic, choice among many plans, has undermined the effectiveness of the program itself.

Findings of the Study

The following are the findings of the study:

- Choice among many plans in FEHBP gives workers and retirees an opportunity to elect plans that most closely match their expected need for medical services. Enrollees can also elect plans that require lower premiums.

- These selections are generally in the interest of the individual enrollee, but can be "adverse" to the collective interests of an insured group. To guard against adverse selection, many plans design benefits to appeal to lower-risk, and discourage higher-risk enrollees.

- Choice among plans, in conjunction with the method by which the Federal share of premiums is calculated, has resulted in concentrations in some plans of persons with similar risks. This phenomenon is called "risk segmentation."

- Risk segmentation has led to substantially different premiums for the benefits of some plans, relative to the premiums that would occur if the plans covered the entire FEHBP population. For instance, a measure of standard benefit value shows a range of 46 percent in the value of benefits in FEHBP plans, while the range in their total premiums is 246 percent.

- This disparity in benefit values allows some enrollees to gain advantages, the sum of which largely match disadvantages borne by others. Because the Government generally contributes a fixed amount toward each plan, premium differences from plan to plan due to risk segmentation affect costs primarily borne by enrollees.

- The evolution of benefit packages makes informed choice difficult. About 16 percent of enrollees are in plans that have "scheduled allowances" for provider payments that can make financial exposure difficult to recognize About 34 percent are in plans in which total premiums exceed the standard value of benefits.

- The presence of choice among plans does not have a significant effect on total program costs. However, the formula for calculating the Federal share of FEHBP premiums interacts with choice in a way that causes the Government share to rise.
- Federal payments for health insurance for the average Federal employee are approximately $1,100 per year less than employer payments for health insurance of a typical private sector corporate counterpart.
- In FEHBP, the average enrollee pays about 29 percent of the average cost of benefits. This average enrollee share of benefit costs represents about 34 percent of costs of active workers, about 38 percent of costs for annuitants covered by Medicare, and about 18 percent of costs of annuitants in FEHBP only.
- If the Government paid the same share of benefits for annuitants covered by Medicare as a group as it now pays on average for the program as a whole (71 percent), then their average premiums could be significantly lower.
- Many annuitants in FEHBP and also covered by Medicare, waste thousands of dollars of their own money by being in plans that require high premiums for benefits they cannot use.
- Nevertheless, on average, Federal annuitants covered by both Medicare and FEHBP have benefit payments from FEHBP that exceed their premium payments.
- Average increases in total program costs over the last 10 years are not unusual when compared to the experience of private sector health insurance plans.
- Money could be saved by adopting cost controls throughout the program and by eliminating unnecessary expenses not related to claims payments.
- More effective administration of the program is possible, and incorporating private sector innovations in health plan management could improve its operations.
- Major structural change to the program could solve perceived problems, but would not save money unless it were coupled with benefit reductions, more cost shifting to participants, or direct controls on providers.

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May 8, 1990

TO : Honorable David Pryor
Chairman, Subcommittee on Federal Services,
Post Office, and Civil Service
Committee on Governmental Affairs

FROM : Janet Lundy
The Federal Employees Health Benefits Team

SUBJECT : **Response to Senator Pryor's Questions**

This memorandum provides answers to your questions following the Committee's April 20, 1990 hearing on the Federal Employees Health Benefits program (FEHBP).

1. **QUESTION**: Assuming the Federal Government can use its large purchasing power to bargain with pharmaceutical companies for prescription drugs for FEHBP enrollees, what issues should be considered in designing a cost-effective prescription drug benefit program?

ANSWER: The following issues might arise in designing a prescription drug program that negotiates with pharmaceutical companies:

a. Would such a program result in savings? Would any savings outweigh the cost of program administration? Could more savings be achieved by using this method than by negotiating with pharmacies, altering benefits design, or using some other cost control mechanism?

b. Would the program use a formulary to determine which drugs would be covered? Would generic or therapeutic substitution be encouraged/required?

c. Who would conduct the negotiations with drug manufacturers?

d. What procedures would be used for enrollees to obtain their prescription drugs? Would FEHBP use participating pharmacies? How would payments from FEHBP to the pharmacies or to the manufacturers be handled?

e. What impact would any limits on choice of pharmacy or choice of prescription drug have on FEHBP enrollees?

f. What would be the impact of such a program on pharmacies and on drug manufacturers?

2. **QUESTION**: Please identify the 2 fee-for-service plans having prescription drug card program and the 14 plans having mail order prescription drug programs under FEHBP.

ANSWER: According to information provided by the Office of Personnel Management, the two 1990 plans with drug card programs are the NTEU Health Benefit Plan and the NFFE Health Benefit Plan. The 14 plans in 1990 with mail order programs include the AFGE Health Benefit Plan (High Option), Alliance Health Benefit Plan (High and Low Options), Service Benefit Plan (High and Low Options), GEBA Health Benefit Plan, Government Employees Hospital Association Benefit Plan, Foreign Service Benefit Plan, NAGE Health Benefit Plan (High and Low Options), NTEU Health Benefit Plan, NAPUS Health Benefit Plan, NFFE Health Benefit Plan, Postal Supervisors Health Benefit Plan, Postmasters Benefit Plan (High and Low Options), Rural Carrier Benefit Plan, and SAMBA Health Benefit Plan.

QUESTION: What has been the plans' experience in controlling rising drug costs?

ANSWER: According to information provided by the Office of Personnel Management, prescription drug costs under FEHBP have been increasing more rapidly than the costs of other medical services in spite of the addition of mail order drug programs during the 1980s. Whether these increases would have been larger in the absence of such programs is uncertain. Although the unit cost for a drug is generally lower through a mail order program compared to a fee-for-service plan benefit, total costs may be higher because of greater utilization, waste, or lower enrollee cost sharing.

3. **QUESTION**: What is the private sector doing to contain prescription drug costs?

ANSWER: Private sector health plans are using a number of mechanisms to contain prescription drug costs, including:

a. *Benefit Plan Design*. Plan design includes the use of enrollee cost sharing (e.g., coinsurance, deductibles); prescription drug plans that are separate from the employer's other health care coverage to better monitor and control utilization and costs; and exclusion of certain drugs such as fertility drugs, anti-cigarette drugs, and experimental drugs.

b. *Mail Order Programs*. Mail order programs are used for long-term maintenance drugs, generally emphasizing generic substitutions. The Bureau of Labor Statistics survey of 1988 employee benefits in medium and large firms found that 7 percent of participants in such plans had higher payment rates for mail order drugs.

c. *Purchasing*. According to information presented by Jonathan T. Edelson, president of Medical Decision Resources, Inc. (a Massachusetts-based consulting firm), as reported in "Spencer's Research Reports on Employee Benefits," March 1990, there are a number of purchasing approaches:

- open a company pharmacy and buy drugs wholesale;
- negotiate discounted rates directly with pharmacies, and direct employees to these preferred providers through employee cost-sharing incentives or penalties (also known as participating pharmacy plans or prescription card plans);
- hire a consultant to organize a network of discount providers;
- develop or join a purchasing group to negotiate discounts with manufacturers; and
- use health care providers that purchase medications in high volume consortiums.

d. *Generic Drugs*. Employers may require use of generic drugs or may encourage their use by applying lower enrollee cost-sharing requirements. The Bureau of Labor Statistics survey of 1988 employee benefits in medium and large firms found that 10 percent of participants in such plans had higher payment rates for generic prescription drugs, an increase from 7 percent in 1986.

e. *Formularies*. Employer plans may limit covered drugs to those determined by the plan to be safe, efficacious, and economic. Formularies can control drug costs by limiting the number of drugs and the number of brands of a drug covered by the plan. Through the formulary, the employer can encourage the use of generic drugs or therapeutic alternatives.

f. *Drug Utilization Review*. Employers use drug utilization review to oversee the medical appropriateness of drug usage under their plans. Such review may include examination of the necessity of prescribing the drug, the appropriateness of the treatment, alternative therapies, and individual physicians' prescribing patterns.

TESTIMONY
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

REFORM OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

BEFORE THE

SUBCOMMITTEE ON FEDERAL SERVICES,
POST OFFICE AND CIVIL SERVICE
GOVERNMENTAL AFFAIRS COMMITTEE

UNITED STATES SENATE

BY

HARRY P. CAIN, II
SENIOR VICE PRESIDENT
FEDERAL PROGRAMS

APRIL 20, 1990

Mr. Chairman, I am Harry Cain, Senior Vice President of the Blue Cross and Blue Shield Association. My responsibilities include administration of our contract with OPM for the Federal Employees Program and our contract with the Department of Health and Human Services (HCFA) for Medicare intermediary services. On behalf of the 74 Blue Cross and Blue Shield Plans that participate in the Federal Employees Health Benefits Program (FEHBP), I want to express our appreciation both for your action in holding this hearing and for our opportunity to testify.

The Blue Cross and Blue Shield Association has been extensively involved in providing health benefits to Federal workers and retirees since the program's inception in 1960 and we are strongly committed to the success of the overall program. Nearly 1.7 million Federal workers and retirees are now enrolled in the Blue Cross and Blue Shield Service Benefit Plan, representing coverage of about 4 million individuals. Approximately 39 percent of all the enrollees in the program have chosen Blue Cross and Blue Shield. In addition, 37 of the Blue Cross and Blue Shield Plans have, in total, 85 HMOs which participate in FEHBP under separate contracts with OPM. Those HMOs serve about 140,000 Federal employees and annuitants.

Given the focus of this hearing, I should also mention that Blue Cross and Blue Shield Plans serve as intermediaries and carriers for the Medicare program. We began that responsibility in 1966, and currently handle about eighty (80) percent of the third party administrator functions for HCFA for the Medicare program. If the OPM proposal to self-insure the FEHBP is adopted by the Congress, our experience in Medicare may be highly relevant. My comments below will highlight that point.

We commend the subcommittee for moving quickly to examine the important issues raised in the recent reform proposal put forward by the Office of Personnel Management (OPM). The OPM proposal provides a useful basis for discussion. It is another contribution to what is becoming a very long debate regarding FEHBP reform. You may remember that this program reached a crisis stage, for a variety of reasons, in 1981. In our communications with the Congress on that occasion we explicitly called attention to the serious problem of adverse selection which was undermining this otherwise popular and successful program. The difference between 1981 and today is quite striking in that there is now widespread agreement that adverse selection is indeed a fundamental problem affecting all parties participating in the program. Recent analyses commissioned by OPM (the TPF&C Report) and those undertaken by the Congressional Research Service (CRS) have been helpful in gaining both an understanding of and agreement on FEHBP's problems. Unfortunately, there is much less agreement on what might be the best solutions to those problems. You have our commitment to work with you and your counterparts in the House of Representatives as you examine options to reform this admittedly complex program.

While the FEHBP has serious problems, the Committee should be assured that it is not on the verge of collapse. The single most traumatic event in the program's history -- Aetna's sudden withdrawal -- took place a few months ago and was managed without major disruption. Moreover, according to the CRS study, the program's costs, though rising and higher than necessary, are increasing at a lesser rate than the costs experienced by private sector employers. And according to our surveys of FEHBP subscribers, most employees and annuitants participating in the program are satisfied with most aspects of the program. Thus we believe that there is ample time to consider FEHBP reform in a very careful, deliberate fashion.

What's the Problem?

In the eyes of most people, the FEHBP has many different problems, including an antiquated government contribution formula, some confusion among beneficiaries, a very unclear connection between the price and the value of the various plans offered, and a total cost which continues to rise in large and unpredictable ways. We would agree with most of those characterizations, but in one way or another each of them is caused by or is a reflection of the one underlying structural flaw in the program, namely the segmentation of risks. Risk segmentation (or "adverse selection") is the most serious problem in the FEHBP, a problem that directly attacks the basic purpose of insurance, i.e., the spreading of risk over a wide population base. If the Committee focuses on that one basic issue and on the various ways it can be managed, the Committee will have a real handle on FEHBP Reform.

The OPM Proposal

The OPM reform proposal does recognize risk segmentation as a fundamental problem and proposes three basic actions to cope with it. One is to self-insure the fee-for-service segment of the program, a second is to create a separate risk pool for annuitants, and the third is to adjust the government's contribution to HMOs in order to offset or compensate for risk segmentation between the HMOs and the self-insured program. We strongly question the wisdom of the first of their strategies, namely self-insurance, but we would support the other two. There are other components to OPM's proposal, such as buying into Medicare those annuitants who are over sixty-five but not Medicare eligible, which we would strongly support. For purposes of sharpening the debate, however, the remainder of this testimony will focus on the issue of self-insurance. I will review the arguments for self-insurance and their applicabililty to FEHBP, then will look at the hazards of self-insurance and their potential consequences. I will also comment on the larger differences between today's program and the self-insurance model, and then will offer a set of principles that we believe should guide reform. Finally, as you requested, I will comment on the relevant proposals in the President's 1991 budget request.

The Arguments for Self-Insurance

The notion that the government should self-insure the indemnity portion of the FEHBP appears to be based primarily on the model of large private employers who self-insure. Based on our experience in serving large private employers, that model is deceptive and cannot be simplistically applied to the governmental environment; it requires analysis. First, it is necessary to examine why many large private employers have self-insured and whether their rationale is consistent with the government's needs. Second, it is important to look at the federal government's experience with self-insuring large health care systems and the lessons that might be learned from that experience. Third, there is enough dissatisfaction among both private sector and governmental self-insurance programs that both are now moving in the other direction, back toward risk sharing with private carriers. The FEHBP reform effort should be oriented to the future, not the past.

Why have many private employers opted to self-insure their programs? A primary reason is to avoid state-mandated benefits. The Employee Benefits Research Institute (EBRI) reported in a March 1990 Issue Brief that "According to a recent study, 51 percent of the firms that converted to self insurance from 1981 to 1984 indicated that state mandated benefits were the primary motivation for the change." EBRI's Issue Brief also notes a second major reason for self insurance which is that self-insured employers are able to earn interest on their reserves and retain any surpluses, whereas this money is usually retained by the insurer in commercially purchased plans.

The FEHBP already enjoys these two major advantages of self insurance. The Federal Employee Health Benefits Act provides a federal preemption over state-mandated benefits. FEHBP is not affected by state mandates. And OPM through its regulatory power has long required that all reserve interest earnings be credited to the program;

such earnings are not retained by FEHBP carriers. More recently, OPM required that reserve funds be maintained "on budget", to improve the government's cash management practices; reserve payments are made to carriers under a letter of credit arrangement. Thus the major private sector reasons for self-insuring do not apply to the FEHBP.

A third reason private employers sometimes opt for self insurance is to reduce health plan costs by avoiding the state premium taxes levied on insurance companies. OPM has proposed to seek legislation to exempt the FEHBP from state premium taxes. Such an exemption would be consistent with the current exemption from state mandated benefits, and would be a immediate and sensible money saver. The Blue Cross and Blue Shield Association supports this aspect of OPM's proposal.

Another reason cited by OPM for going to self-insurance is to reduce administrative costs. Private employers have not found that to be a major advantage of self-insurance, but the government may well be incurring higher than necessary administrative costs in the FEHBP currently. We would agree that administrative costs can be lowered (though going to self insurance is not necessary to do it), but this is a deceptively simple issue. On the one hand, administrative costs amount to less than ten percent of the cost problem (though they often get eighty percent of the attention), and on the other hand, cutting administrative costs is frequently a penny-wise, pound-foolish maneuver. Our most effective cost containing mechanisms require the investment of administrative dollars, but yield a very high return in the savings of benefit dollars, usually on the order of 10:1 or higher. The future will unquestionably demand such strategies as more tightly managed care, more incentives to use some providers and not others, and more cost containment techniques. These strategies will require more administrative dollar investment, but the return will be many times the investment.

If the reasons normally cited by private employers for self-insurance do not apply to the FEHBP, then why is OPM/OMB arguing for self-insurance? Obviously we don't know the answer to that, but we would guess that the primary objective is to strengthen further the Executive Branch's hand in reducing resources spent on the Federal employees' and retirees' health benefits. That is a very understandable motivation, but we believe it is hazardous, certainly for the current beneficiaries, carriers, and HMOs, and also for the government as an employer. We would urge this Committee to focus on the long-run impact of self-insurance on the quality of benefits, the quality of service, the level of choice available to individuals, and not least, the character of the decision making process that will control health benefits for Federal employees and annuitants. The aggressive pursuit of cost savings is obviously essential -- but should be, and can be, done in ways certain to protect the quality of benefits and service. The question this Committee may want to consider is, when both the Administration and the Congress place a very high priority on reducing the Federal deficit, by any means possible, what is the likely consequence of the government's holding all the financial risk for the Federal Employees Health Benefits Program?

The Hazards of Self-Insurance by the Government

Self-insurance is not necessary to achieving lower costs, enhanced benefits, or greater stability to the FEHBP, and in fact could make it more difficult to achieve these goals. It could be a bitter pill for both enrollees, and over time the government to swallow, not the panacea its advocates claim. Despite the best intentions of its advocates, if history is any guide, it will simply provide government budget examiners with greater opportunity to reduce benefit levels, delay claims payments, or short-change enrollee service.

The Medicare program provides one example of the hazards of self-insurance by the government. Because the government bears the overwhelming share of the risk in

Medicare, it places high priority on both squeezing its own benefit payments and minimizing administrative costs. Technological advancements and total benefit/service improvement techniques that would result in better quality care, better beneficiary service, and lower overall costs in the long run repeatedly are given short shrift in favor of the current year's budgetary dictates. Often, the government's approach to funding bears no resemblance to reality.

This point is dramatically illustrated by the chart attached to our testimony which depicts the annual growth in Medicare claims. A review of the percent change in Medicare claims volume from 1983 to 1990 reflects an average annual growth of 11.1 percent. At no time during that period has the annual increase been less than 7.9 percent. Yet, apparently to reduce the appropriations needed for 1991 claims processing, the President's 1991 budget estimated essentially no increase in claims volume! Most observers agree that the consequence of the President's budget in that arena would leave 50 million claims unprocessed and unpaid.

This artificial approach to financing forces the Medicare contractors, year after year, to come directly to the Congress and petition for sufficient funding just to keep pace with the growth in claims and inflation.

Sometimes, rather than recommend adequate funding, the Executive Branch has simply slowed down Medicare claims payments. Congress has also found opportunities to use claims slow downs to obtain annual outlay reductions. That saves money only in the artificial sense of moving the expenditure to another year.

On the other hand, the annual effort to reduce "controllable" Medicare spending can be very expensive to the program. Last year, we estimate that the government lost approximately $2 billion from the Trust Fund by underfunding the payment safeguard activities of medical review, audit, and coordination-of-benefits. (Those activities, which yield an average return of 10:1 were cut by about $200 million.) The impact of Gramm-Rudman reductions, when and if they occur, tend also to reduce administrative activities (more than benefits, which cannot be cut more than 2%). The impact shows up in reduced beneficiary services, delayed hearings, and suspended claims.

In terms of Medicare benefit payments, the Administration and the Congress fight annually over the amount of the reduction in payments. Not wanting to make the beneficiaries suffer, nearly all of these reductions are aimed at the providers of health care. Given the deficit problem, whether this can continue without reducing the supply of providers willing to serve Medicare patients or without leading to higher cost-sharing requirements on beneficiaries is an open question.

FEP enrollees now know that when they go to a hospital or a doctor, payments to the hospital or doctor are determined using the same methods used for privately-insured patients. There is not a special lower rate for the Federal employee. This assures him or her of equal access to the health care delivery system.

The Health Care Financing Administration and many others have long since concluded that there must be a better way to administer the Medicare program, to ensure that costs are kept under control while quality of care and service remains assured. While no one knows all the answers, the best bet is the one HCFA has been trying in several different ways for the last several years, mainly to shift the risk back out to private sector parties who have a strong incentive to keep the beneficiaries satisfied and who also must keep costs under control or suffer serious financial consequences. We believe that this is the direction of the future and would recommend that this Committee look at that experience before deciding on a course of action for FEHBP.

In a similar vein, you might also note the experience of CHAMPUS, heretofore another totally self-insured program using private carriers in only an administrative capacity. (Blue Cross and Blue Shield Plans handle most of the CHAMPUS work as well.) After many years of budget overruns, and being forced to return to Congress for the supplemental appropriations needed to pay the bills, the Department of Defense tried to reform the program by shifting the risk back to the private sector. Only an experimental part of that effort went forward, but now CHAMPUS is hailing the success of that experiment and wants to expand it. In short, the record of the government's self-insured programs is not one to inspire confidence in a self-insured FEHBP.

Just as in the case of Medicare and CHAMPUS, many private employers have determined that self-insuring has not produced the desired results and are returning to full risk or risk-sharing arrangements. Southwestern Bell and Allied-Signal are two prominent examples. The March 1990 EBRI _Issue Brief_ showed a 3 percent decrease in self-insured plans from 1986 to 1988, and that trend is accelerating. This Committee might also want to look at the new directions underway in the private sector.

Isn't FEHBP Almost "Self-Insured" Already?

One of the arguments occasionally used in favor of self-insuring the FEHBP is that the program is "almost self-insured now, so what's the difference between today's program and going all the way to self-insurance?". In the same vein, some people have asserted that "in today's FEHBP there is very little risk for the carriers anyway." We believe that those are misleading statements in at least two respects. First, there is more risk for carriers currently in the program than is generally understood (and that risk does motivate carrier behavior), and second, there would be a major reduction in choice. I would also note that there could be major reduction in service available to employees and annuitants, if the self-insurance argument prevails. Let me address these points.

First, regarding risk, the fact that a carrier participates in the program by virtue of being specified in the FEHBP legislation, and that the premiums are based on the experience of the enrollees, does not mean that a carrier can ignore the cost of its health plan. While it is true that FEHBP carriers can attempt to recoup losses by building their cost experience into their rates, it must be kept in mind that in a price competitive market an insurer with excessive losses and subsequent excessive premiums will be unattractive to enrollees. Knowing that rates can be set to cover costs is no comfort to an insurer who is priced out of the market. In that situation, previous losses cannot be recovered.

OPM will tell you that over the last ten years insurers have suffered real losses of not more than a hundred million dollars in the FEHBP. From OPM's perspective, that amount may appear to be insignificant, as a percentage of the total program, but to the private companies who suffered the losses, I can assure you that the pain was real. To slightly modify the late Senator Dirksen's famous phrase, "Losing a hundred million dollars here or there might someday add up to real grief!"

Moreover, thus far only smaller plans have sustained non-recoverable losses. We understand that Aetna managed to return to a positive financial position before announcing its withdrawal, but it withdrew from the program because it knew that the risk of large losses was very real.

You see, whenever a carrier leaves the program it cannot take any reserve surplus it might have. All surpluses revert to the program. Carriers must, however, absorb any losses. Losses are not shared with the program. Maybe that doesn't look like risk to some people, but it does to us and that risk does in fact provide strong incentives to manage our plan in a prudent, cost conscious manner.

What about the impact on the beneficiary of a self-insured program? One of the advantages of today's program is that each carrier has a strong incentive to obtain or maintain as much enrollment as possible. Among other things, that means that we must provide satisfactory levels of service to our subscribers or they will go elsewhere. Under a self-insured program, whether we or any other carrier served as a third party administrator, there would be one level of service available to the beneficiary, no matter which benefit option the beneficiary chose. That is, under OPM's proposal, a beneficiary in any region of the country would have one company to deal with, and no other choice. While beneficiaries could enroll in HMOs, all those who preferred a broader choice of providers (physicians, hospitals, etc.) implicit in a fee-for-service plan would have to obtain their coverage and their claims management from one OPM-selected vendor.

As an aside, I would like to comment further on the issue of choice, and its popularity among the beneficiary population. We have certainly agreed with OPM in the past that the amount of choice available in this program currently exceeds what anybody rationally might want.

Moreover, the amount of choice has created some of the severe adverse selection problems I referred to earlier. Nonetheless, our surveys of the beneficiaries indicate that wide choice of plans and carriers is the single most popular characteristic of this program. As a policy matter, we would not argue in favor of retaining as many choices as are now available, but the Committee should not believe that a major reduction in the amount of choice will be popular among the affected population.

Beneficiaries are likely also to be affected by another dimension of self-insurance. And this one may reflect some lack of appreciation of the services routinely performed by current FEHBP carriers. The carriers' current ability and willingness to maintain an uninterrupted stream of benefit payments to hospitals, providers, and enrollees -- even if OPM or the carriers underestimate the necessary premiums -- appears to be taken for granted. This would not be the case in a self-insured program. Third Party Administrators will pay only those claims and expenses for which the government has provided real dollars. Because the disruption that would result from insufficient appropriations has not been generally experienced (except for the 1982 benefit cuts), it is easy to assume, incorrectly, that such a problem could not happen to a self-funded FEHBP.

Principles for Reform

We believe there is a more appropriate path to take in pursuing FEHBP reform -- one that uses the private insurance sector to maximum advantage for both the government and the enrollees. We can build on the strengths and address the weaknesses of the current program. The government can be a more prudent buyer, the incentives in the program can be changed to help mitigate adverse selection, and beneficiary choice can be preserved. We find there are a number of different ways one might achieve such an improved program. I would like to share our sense of the principles which should underlie basic reform of the program.

Enrollee choice of benefit plans and carriers can and should be managed to minimize the negative effects of risk selection. The costly inequities created by the segmentation of risks in the current FEHBP can be addressed not by eliminating choice but by managing it better. Program features designed to manage choice more effectively can minimize adverse selection against individual plans (and their enrollees) and the government.

Competition among FEHBP carriers is desirable but it should be based on the value of the insurance protection provided, the effectiveness of cost containment efforts,

and the quality of service provided to enrollees. The only way to do that, and still leave a wide range of choice for beneficiaries, is to adjust the government's contribution to reflect risk segmentation. OPM's proposal includes two features which would largely accomplish that: (1) a separate risk pool for annuitants, and (2) an actuarial adjustment of the contribution to different carriers and HMOs. Alternatively, the government's contribution could be adjusted for actives, annuitants without Medicare, and annuitants with Medicare, without creating separate risk pools.

The assumption of insurance risk by carriers is key to effective cost containment in the FEHBP and responsive service to enrollees. Both the government and FEHBP enrollees are best served if carriers are financially accountable not just for processing claims or performing specified administrative functions but for managing the health benefits program effectively. Effective management, in a competitive environment not distorted by severe risk segmentation, means keeping costs (and therefore premiums to both enrollees and the government) down without sacrificing enrollee access to mainstream medical care or prompt claims service. A private carrier at risk in the FEHBP has the best incentives for innovations that better serve the objectives of the program.

The FEHBP should continue to be an employee benefits program, not a social insurance program or experimental laboratory. The design and operation of the FEHBP should reinforce the government's overall program to attract and retain highly qualified staff. To the maximum extent feasible, the government should, through the FEHBP, provide employees with the access and service that is available to private sector employees. From the perspective of the health care delivery system, the FEHBP enrollee should be considered as any other citizen with employer-provided health coverage, not as the recipient of government-financed benefits. Similarly, while innovations in the FEHBP should be encouraged, these innovations should be focused on the fundamental purpose of the FEHBP as an employer health plan, not on reforming the delivery system or maximizing the government's negotiating leverage.

Post Script on the President's 1991 Budget Proposals

Mr. Chairman, you also asked for our opinion on the proposals contained in the President's 1991 Budget regarding FEHBP. I will comment on those proposals relating to state premium taxes, consolidating and reducing reserves, and changing the government contribution formula.

As indicated earlier, we would actively support the proposal that the FEHBP be exempted from state premium taxes. That would be consistent with the general FEHBP exemption from state mandates.

The proposal to combine all carriers reserves into one reserve pool and to reduce that pool to one month of probable claims payment would be foolhardy, in our view, and we would strongly object to it. Those proposals would make sense only if the program were a self insured program. To make that change under any other circumstances would be very risky. (Moreover, it in fact entails no savings whatsoever, even in the unusual way the Federal government keeps its books. Reducing and comingling reserves would not diminish the outlay of funds required to keep the program going.)

We understand that if the Administration's self-insurance proposal is not enacted, OMB would then propose a change in the government contribution formula currently governing the FEHBP. The proposal would use a weighted average of all premiums (rather than the "Big Six" high options) as the base line, and perhaps would change the current sixty percent contribution level to some other, higher figure.

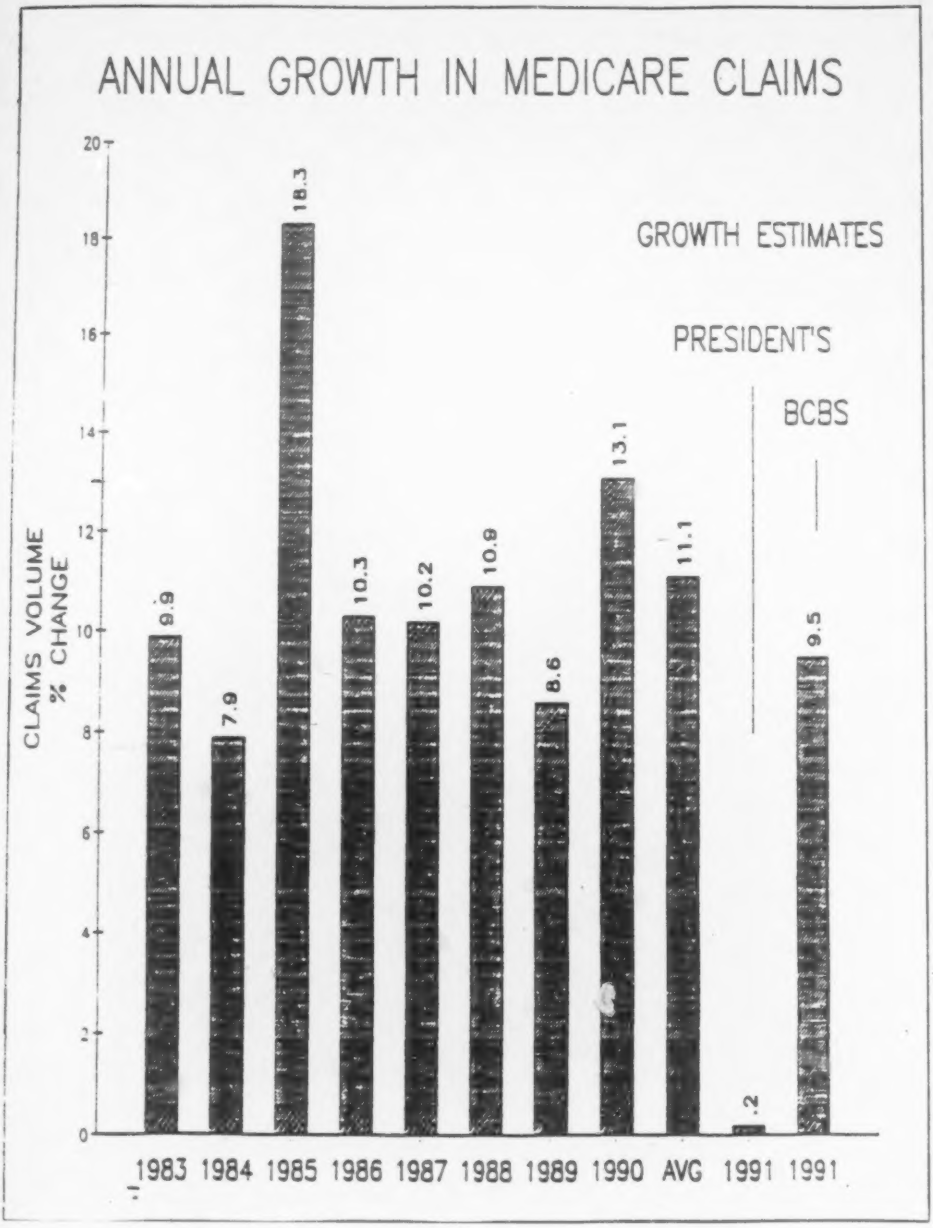
The "Big Six" formula was devised in the first place to ensure that the government's contribution level was gauged against a relatively generous set of benefits (high options) available to a broad cross-section of the Federal population. (Originally, the designers of FEHBP, and we, assumed that most of the population would choose the "low options" of the government-wide plans, not the high options. We were wrong.) Over time it was the adverse selection dynamic that drove the costs of the two government-wide high option plans to such heights, and that in turn pushed up the government's contribution level further than had been intended.

Given the departure of one of the Big Six, it does make sense to change the formula, but it should be done in a way that does not exacerbate the adverse selection problem. Putting that another way, if the contribution formula is not changed carefully, there will either be a cost shift to all employees and annuitants, or a large cost shift to the older, less healthy members of the population, or both.

Summary

In summary, we believe that the self-insurance "cure" could generate more dissatisfaction than the maladies now plaguing the program. Though enrollees may see reform as a means to obtain enhanced benefits and/or reduced premiums, the self-insurance concept would instead create a dynamic of greater uncertainty over benefit levels and claims service and significantly reduced choices. We are proud of our record of serving Federal employees and retirees who have chosen the Blue Cross and Blue Shield Service Benefit Plan for their health insurance. We believe that we and other experienced private carriers are better positioned than either OPM or OMB to manage health benefits in a manner that appropriately balances the need for cost containment with enrollees' needs for benefits and service. We urge you to reject the self-insurance concept and examine alternative approaches based on the principles we have suggested.

Thank you.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Supplemental Questions for Harry Cain from the Senate Committee on Governmental Affairs

1. You state that Blue Cross and Blue Shield is opposed to mingling the carriers reserves. What are the possible implications of such change?

   Answer: Achieving and maintaining a reasonable set of reserves is a critical component of any underwritten health insurance program. Such reserves serve both to keep the level of risk within prudent bounds and to moderate the degree of change in premium rate from one year to the next.

   If the OPM obtained authority to "mingle the reserves", we literally don't know how the program would work. Would it mean that any carrier which had exhausted its share of reserves could use reserves contributed by other carriers? Would it mean, for example, that Blue Cross and Blue Shield subscribers' premium contributions (some of which go into our reserves) could be used by the NFFE or the Letter Carriers plans if they ran short of reserves? This would result in our subscribers premium contributions paying for NFFE or Letter Carriers subscribers benefits. Would it mean a "bail-out" of any plans now in a serious deficit position? The concept is simply incompatible with the current structure of the FEHBP. We suspect that the proposal reflects the OPM/OMB desire to have the government self-insure FEHBP and to get the private carriers out of the program, at least as underwriters. Frankly, I do not know how we could agree with OPM on premium rates for 1991 (or any future year) if "reserve mingling" were OPM's policy. (Parenthetically, this measure would not save any money!)

2. One of the suggestions that you make is to separate employees from retirees and create a separate "risk pool" for annuitants. Currently, annuitants with Medicare coverage who have Blue Cross High Option are believed to subsidize the program, since Medicare is the primary payer. What effect would a separate risk pool have on the premiums for both employees and retirees?

Answer: The question has several components. First, regarding whether one subgroup "subsidizes" other subgroups, the issue goes to the heart of insurance. In any insurance program, the idea is that the majority who do not use their full benefit will "subsidize" the minority who need it.Thus there must always be subsidization if the idea of insurance is present. In terms of the FEHBP, it is probably most accurate to say that the active employees and the annuitants with Medicare together "subsidize" the annuitants without Medicare. The actives and Medicare eligible annuitants resemble each other very closely in terms of their costs to the program. The annuitants without Medicare, on the other hand, have a per contract cost which averages about twice as much as the other two subgroups. (It should be understood that the Medicare eligible annuitants have a significantly richer total benefit package, with an augmented FEP plan plus Medicare, than have the other two groups.)

The idea of separate risk pools is aimed at two objectives: (1) coping with the adverse selection problem which occurs when some subgroups of high utilizers (e.g., annuitants without Medicare) congregate in only one or a few plans, and (2) allowing for a different kind of health benefit plan to be designed for retirees, reflecting for example their greater need for long-term care services, but their lesser need for obstetrical services.

If annuitants and actives were in separate risk pools, the per person premium cost of the annuitant pool would of course be much higher than in the active pool. The out-of-pocket costs to the subscribers would depend upon the level of the government's contribution. The government could make the out-of-pocket costs for the two pools exactly the same, or it might make the out-of-pocket costs for annuitants higher than for actives.

The most practical problem facing the creation of separate risk pools is what to do with the annuitants who are not eligible for Medicare. For those who are 65 and over, one approach would be to "buy them into Medicare"; then all Medicare eligibles could create a pool for a Medicare supplemental plan. That would still leave a few hundred thousand people who are retired but under the age of 65. For them, either a third pool should be created, or they would remain in the active pool, "subsidized" by the active population.

Another approach to resolving the same issue would be to leave the actives and the annuitants without Medicare in the same pool, but allow the government's contribution for the annuitants without Medicare to be higher than for the actives (while keeping the employees' and annuitants' share the same). Such a "risk adjuster" would offset at least part of the higher cost to carriers of the adverse selection effect.

In fact, unless the government wants to create a very different kind of program (e.g., a Medicare supplemental program only) for the Medicare eligible annuitants, it would not be necessary to create any separate risk pools. The government could accomplish its ends simply by adjusting its contribution to reflect the level of risk involved in each case, again leaving equal the out-of-pocket costs for all subscribers.

3. How has your experience in FEHBP differed from your experiences as a health insurance carrier for non-Federal program? Other than risk segmentation which seems to be a direct result of the choice inherent in the program, are increasing medical costs and difficulties in developing efficient cost containment mechanisms similar in most areas of the health insurance field?

Answer: The annual choice characteristics of FEHBP (which many other large employers now also offer) compounds the cost containment problem in two respects. First, it can create an ever changing population of subscribers, so that informational and educational efforts can be lost as subscribers move from one carrier to another. (Affecting subscribers' attitudes and knowledge regarding health care is a critical component of cost containment in the long term.) Secondly, to the extent that some cost containment programs are tangibly unattractive to subscribers (such as requiring subscribers to get preapproval for certain activities or face a large financial penalty), the carrier may be "chasing away" some of its subscribers. These kinds of programs can only work if every participating carrier is required to use them. (Having every carrier use such measures would be more effective, in cost containment terms, but would not reduce the level of subscriber dissatisfaction which such measures tend to generate.)

On the other hand, many effective cost containment devices can be "invisible" to the subscriber. For example, some of our programs put the entire burden on the physician or the hospital to secure approval or clearance before certain procedures or actions can be covered. That kind of cost containment is not affected by the annual choice characteristic of the FEHBP.

In the more general sense of the question, the cost containment challenges in the FEHBP are quite the same as the challenges elsewhere. Everywhere we face a population which is aging, and thus requiring more care; everywhere new medical technologies are making more kinds of treatments possible, usually at a higher cost; everywhere we face the problem that some hospitals and physicians are more consistently high quality, efficient providers than are others, and it is often difficult to direct subscribers to the more efficient and away from the less efficient. We are finding that, by using some of the characteristics of both HMOs and PPOs, we are improving our ability to make the kinds of discriminations necessary, and to create the kinds of incentives in our benefit packages which will direct most people in the most cost effective direction.

4. You say that FEHBP would be better run if carriers were accountable for "managing" the health benefits program. What exactly does that mean? What would Blue Cross and Blue Shield do differently if they had "management" responsibility for their program?

Answer: I think the question is based on a misinterpretation of my testimony. I had intended to suggest that keeping private carriers at risk (and allowing them to continue to manage their benefits as well as possible) would be more effective than a self-insurance program by the government in which third party administrators would simply follow OPM's directions. Under the current program, we do largely have responsibility and major incentives for managing our own programs. Of course, there are some elements of today's program that we would like to see changed, in order to give us more management flexibility (such as having the authority to offer a third option, probably a more heavily managed "economy" option), but compared to the proposal advanced by OPM, we are not complaining about our current management authority and accountability.

5. If the government moved to self-insurance, you seem to suggest that FEHBP would be even more vulnerable to benefit reductions and increased costs to participants because of the increasing deficit. Is that a correct interpretation of your concern? Is this what you have seen happen in Medicare?

Answer: In general, that is a correct interpretation of my concern, although I would focus more on the level of service and cost, rather than on benefits, at least based on the Medicare experience. Based on that experience, history suggests that when OMB has more immediate control over annual outlays for health care programs, which self-insurance allows, several things can happen, especially in an era of tight Federal budgets.

- The money needed by TPAs to manage the program and process claims can be arbitrarily slashed, or cut off entirely if appropriations are not adequate and timely. Or TPAs can be ordered to slow down the payment of claims, in order to get some artificial annual outlay savings, penalizing subscribers and providers in the process.

- Or the program will be changed every year, in response to financial or political pressures. Five to eight percent of the annual administrative budget will be needed just to implement the changes.

- Or benefit payment allowances will be cut to fit the budget. Over time that can put the beneficiaries in an uncomfortable position when they go to get health care. How long would any employees continue to have full access to health care if their employer's health benefits program did not make adequate payments on their behalf? Of course, if the employer is the Federal government, it can pass a law requiring that its employees and retirees not be denied services, regardless of the payment level. Then the question might become, how welcome will those beneficiaries be in high quality health care facilities?

> Or (and this probably is the most inevitable result) whether by desire of the Executive Branch or by order of the Congress, the government will increasingly seek to "micromanage" the functions of the TPAs. The responsibilities of the TPAs will be exhaustively detailed, then fragmented, rearranged, pared down, reassigned. The staff of the governmental agency will be very busy, will find itself understaffed, and will grow larger.

In summary, if the sole objective is to reduce or minimize expenditures, or alternatively, to increase the bureaucracy, then self-insurance by the Federal government is probably the thing to do. On the other hand, if the objective is to balance cost containment with quality service, self-insurance is not the road to take. (One further point of clarification: my argument is not against self-insurance per se, it is against self-insurance by the government, given the decision-making processes and propensities which have evolved in government over the last 30 years.)

6. One of the common statements about FEHBP that you try to rebut is that carriers are not at risk in the program.

   a. Is the risk that Blue Cross and Blue Shield faces in FEHBP similar to the risk that you face in your other non-Federal programs?

   b. Do you intend to bid on the military's expanded CHAMPUS program which really does put the carriers at risk?

Answer a. The risk we face in the FEHBP in some respects is greater and in some respects is less than in other non-Federal programs. The factor that makes it greater is the multiplicity of carriers and HMOs participating in the annual Open Season process. The amount of plan switching which happens in most years makes it more difficult to predict our costs for the following year. The greatest risk is that between the time rates are set (July) and the time when Open Season is over (4 or 5 months later), some major unanticipated event would cause a tremendous unexpected shift among the most "mobile" enrollees, resulting in even more serious adverse selection. We do not face that kind of risk in most non-Federal programs.

On the other hand, as long as we manage ourselves prudently in this program, and abide by the law, we are more or less guaranteed the ability to participate in FEHBP. That reduces our risk. It is a characteristic not found in any of our private sector programs. To some extent, those two unusual features tend to balance each other, thus making our total risk in FEHBP roughly similar to private sector risks.

Answer b. In response to question 6b, I can tell you what happened when the CHAMPUS experiment first began. Blue Cross and Blue Shield Plans were very supportive of the CHAMPUS reform initiative, and were very confident of our ability to put together good risk sharing proposals which would be to the government's advantage, and which would also allow us to use all of the skills we had developed in the area of cost containment. The Defense Department however did two things in its reform proposal which caused all but one of our plans to drop out of the bidding. (The one that stayed in was to play only a subsidiary claims processing role for another prime contractor.)

The first problem, from our perspective, was that the Defense Department wanted not only to reform CHAMPUS but to revive the military treatment facilities (MTFs) located on military bases in the geographic areas affected -- requiring the contractors to staff the MTFs with private sector physicians whenever necessary. This raised significant issues of liability which we were never able to resolve.

Secondly, CHAMPUS decided to impose the Medicare DRG system on all CHAMPUS programs, including in the experimental at-risk programs. At that point, one of our largest plans, which had put together a very good proposal, pulled itself out of the competition. In that instance, the Blue Cross and Blue Shield Plan had a set of agreements with the providers in the area, and a cost containment plan that combined the in-patient and the out-patient sectors. The imposition of the Federal DRG system nullified the Plan's agreements with the affected providers, and increased our risk in unpredictable ways. Therefore the Plan withdrew.

I would note that CHAMPUS wanted to get its at-risk experiment off the ground in three separate areas of the country. In two of the areas, after the foregoing episodes took place, there were no proposals (0) for the government to review. In the third area, only one bid remained for the government to consider.

In summary, from our point of view, the Defense Department had a very good idea but tried to build more on to that idea than it could withstand. Thus nearly all the potential competitors were chased away. Whether we would aggressively compete in a future CHAMPUS competition would of course depend on the specifics of the RFP.

7. You are opposed to the Administration's proposal to self-insure. Have you communicated your opposition to OPM? What was their reaction?

Answer: OPM held a few general discussion meetings last year, and we participated in all of them. We did not know of the OPM self-insurance proposal until a draft surfaced earlier this year. When I learned of it, I did immediately write a letter to Ms. Constance Newman, the new director of OPM, outlining our concerns. A copy of that letter is attached. Subsequently, Barney Tresnowski (President, Blue Cross and Blue Shield Association) and I met with Ms. Newman and some of her senior staff to further discuss our concerns. OPM's reaction was essentially to reiterate its support for and belief in the self-insurance proposal.

Blue Cross
and
Blue Shield
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February 15, 1990

Ms. Constance Berry Newman
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Dear Ms. Newman:

I understand from press reports that the Bush Administration is formulating its policy position on FEHBP Reform, and that you are the leader of that activity. For that, and for all your other responsibilities, I would like to offer both sympathy and support. Your challenge is truly daunting.

Based on the reports we've seen, and assorted rumors heard, I believe that there is much in the reform proposals you are considering that we would support, and much that would concern us. Thus, the purpose of this letter is to offer our perspective on the subject, based both on our 30-year history in the program and on our experience with other large employer accounts in the private sector.

First, from our perspective, what is the problem? Although the FEHBP has served the government rather well over the last 30 years, we agree that the program is basically flawed because it promotes competition on the wrong basis. Competition in FEHBP often does not emphasize the value of insurance protection, quality of service, and the effectiveness of cost containment. Too often it focuses carrier attention on the value of attracting healthy risks. The consequent segmentation of risks (or "adverse selection," as some call it) is a major problem, one that has increased as more and more carriers and HMOs have entered the program. It creates costly inequities for both consumers and carriers.

We do not agree with those who assert that the program is on the verge of collapse. The largest single "shock" to the program -- last year's sudden withdrawal of the Aetna plan -- has been managed without trauma. Of course, it is too early to tell the longer-range impact of the movement of the Aetna enrollees, many of whom have now joined our plan. However, we do not anticipate any near-term problems, certainly not in the next two years. Therefore, we believe there is ample time to consider FEHBP Reform in a very careful, deliberate fashion.

In that vein, we do agree with those in the Administration who believe that FEHBP Reform can be a major pattern-setting event in this industry, and that it should therefore be considered in the context of the larger debate over health cost, quality and access problems country-wide. We were encouraged by the President's request that Secretary Sullivan lead an Administration review of this broader and even more challenging set of issues. Presumably, that review will set the backdrop for FEHBP Reform.

What concerns us most about the various proposals for FEHBP Reform is the commonly expressed belief that the government should "self fund" the program, or at least all of the program except for the HMOs. We believe that would not work in the government's interests, or in the interests of its employees and retirees, and let me lay out our reasoning. (Parenthetically, most of the reasoning we have heard in favor of self-funding is not persuasive. Proponents point to the model of large private employers who self insure, but that model is deceptive on two counts: One, government can get, and mostly already has, the advantages of self funding without taking the risk; and two, large private employers are now beginning to move away from self funding, as several private RFPs now on the street are demonstrating. The movement is toward "risk-sharing" between the employers and the carriers.)

In our view, the two most basic issues to address in the FEHBP Reform debate are risk (who should be at risk for making the reformed program succeed?), and competition (what kind of marketplace dynamic, if any, do you want to use in this program?). The two issues are closely interrelated.

We believe that the government should not take on the risk (through self funding), for basically two reasons. First, the government has difficulty in saying "no" to people or organizations that want to participate in any program. The political nature of government makes it the agent of choice if the objectives are to let everyone in, or to promote equality among players, or to enforce non-discrimination across the board. In health care, however, the only demonstrably effective way to contain costs while maintaining quality is to improve our ability to discriminate among the ever growing supply of providers, to include some while excluding others, or to include some on better terms than others. Additionally, as you know, the government has difficulty in acting either swiftly or flexibly; the legislative and regulatory processes are inherently and necessarily slow. The world of health benefits management is changing rapidly.

Richard Darman's introductory remarks on the President's 1991 Budget raised deep concern over the government's assumption of risk in domestic programs across the board. Certainly those concerns must apply to health care programs. In the case of Medicare, where the government has the overwhelming share of the risk, the government has shown itself rather good at minimizing administrative costs and slowly squeezing its own benefit payouts. Everyone can participate in the program, and most everyone does, but the benefits are being reduced on all sides. Interestingly, for at least the last fifteen years, several successive Administrations have tried to move the Medicare risk out of the government and into the private sector (primarily into HMOs).

One can also note the experience of CHAMPUS, heretofore another totally self-funded program using private carriers in only an administrative capacity. After many years of budget overruns, and being forced to return to Congressional appropriations committees for the "supplementals" needed to pay the bills, DOD tried to reform the entire program by shifting the risk back to the private sector. Only an experimental part of that effort went forward, but now CHAMPUS is hailing the success of that experiment and wants to expand it. It entails risk-sharing.

The second reason for opposing self-funding is its impact on the competitive marketplace. We believe that in health care as in most other complex sectors of the economy, the most effective way to generate a continuing stream of new and creative approaches to resolving tough problems (such as how to better contain health care costs while enhancing access and quality) is to let qualified organizations compete for the larger rewards of success (or the greater pain of failure) which the assumption of risk entails. As incentives go, the assumption of risk is in a class by itself! (Along with innovative problem solving, competition also tends to provide significantly more choice for the consumer, not an insignificant side benefit.)

Granted, that can be viewed as just a simplified statement of classical marketplace theory, one that does not have an impressive history in health care financing. Health care has evolved in such a way as to create some serious impediments to marketplace dynamics, such as the difficulty of clearly defining and evaluating the medical "product," the relative power imbalances between consumers and providers, and the high societal and emotional value attached to health care.

Still another, and we believe the most critical impediment to productive competition, is the dynamic of "adverse selection." That dynamic alone has made much of the competition within FEHBP non-productive. If the selection problem cannot be managed, then a competitive market -- for all the advantages it offers -- cannot work in the long run. Fortunately, we believe that this problem, along with the others mentioned above, can be managed -- not totally resolved, but at least managed -- and the creative power of the marketplace can still be harnessed in the provision of health care services. Doing that effectively in the FEHBP, however, will require some changes.

Before moving to the kinds of changes we would recommend, let me mention another problem with the currently popular idea of government self-funding the "fee-for-service" program while letting HMOs participate, as now, on an at-risk basis. Not only does that leave most of the program not at risk, but many innovations in our industry are blurring the distinctions between "fee-for-service" and "HMOs." The fact is that both sides of that line are modifying themselves to become more competitive with each other. I fear that self funding the fee-for-service side would severely limit its capacity (incentive, flexibility, speed) to innovate and compete.

So, what is the answer? In our view, a reformed FEHBP should (a) retain many choices for employees (albeit a more manageable number than currently), (b) create a separate program for annuitants, again with choices, (c) leave a significant amount of risk in the private sector, but (d) only for carriers and HMOs that satisfy stringent OPM criteria.

We believe that the way to manage the adverse selection problem is to (a) establish at least separate pools, if not separate programs, for actives and annuitants, and (b) reduce the number of competitors so that each one can enroll a large number of beneficiaries. One way to do the latter is to competitively select not more than 3 or 4 national carriers to participate, and similarly limit the number of participating HMOs (admittedly a more difficult task). A minimum benefit package applicable to all plans would also be advisable, though it will be difficult to set the minimum. (The minimum should be high enough to prevent "cream skimming" but low enough to allow for strong managed care incentives above the floor.) These measures will not eliminate adverse selection, but will reduce it, we believe, to manageable size. Some experiments currently under way, funded by HCFA, may show us how to reduce the selection problem even further.

Our recommended approach would retain "open season," which both provides choices for employees and keeps carriers and HMOs on their toes. On the other hand, costs and the selection problem might both be reduced if open seasons were held less frequently, perhaps every eighteen months or two years.

As the foregoing suggests, we have enough experience and opinions on this topic to go on at length. In fact, the purpose of this letter has not been to lay out "all the answers;" indeed, we do not believe we know what all the answers are. We do believe, however, that the issues of risk and competition should be at the core of the debate, and that government self funding the program will take it down a less productive road.

I will seek an opportunity in the near future to meet with you, at least to get acquainted. (I think our paths crossed once before, in our earlier lives as HEW employees!) I would hope to exchange views on the state of the current program as well as to discuss any aspect of this letter that you might like.

I presume you are getting other letters, from other interested parties, like this one. Again, you have our sympathy -- and best wishes!

Sincerely,

Harry Cain

Harry P. Cain

Postscript. In the President's 1991 Budget is a proposal to "save" $460 million in FEHBP by combining all the carriers' contingency reserves into one pool, and limiting that pool to "one month." That is an alarming proposal, not only because it really contains no savings (it only spends down reserves; outlays would remain the same), but more importantly because it skews the current risks and reduces accountability among carriers. It means, for example, that if we underestimate our revenue needs, and set our rates accordingly, we will just spend someone else's money when we hit a deficit position! I'm guessing that the author of that proposal is a proponent of government self funding, who decided to shift responsibility away from the carriers in 1991. As you can guess, we will not be able to support that idea.

Postscript. The proposal to exempt the program from State premium taxes is consistent with the long-standing FEHBP exemption from State mandated benefits, and would be an immediate and sensible money saver. We will support it.

STATEMENT OF THE
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

ON THE

FEDERAL EMPLOYEES HEALTH
BENEFITS PROGRAM

ROBERT P. PFOTENHAUER
PRESIDENT AND CEO
GROUP HEALTH ASSOCIATION
WASHINGTON, D.C.

BEFORE THE
SUBCOMMITTEE ON FEDERAL
SERVICES, POST OFFICE, AND
CIVIL SERVICE

SENATE GOVERNMENTAL
AFFAIRS COMMITTEE

APRIL 20, 1990

Good morning Senator Pryor and members of the Subcommittee. My name is Robert Pfotenhauer and I am President and CEO of the Group Health Association, a non profit federally qualified HMO which serves the Washington Metropolitan area. We are a staff model HMO, started in 1937, which now serves 155,000 members. Our enrollment of federal employees, retirees and their dependents is significant -- more than 62,000.

I am here today on behalf of the Group Health Association of America, Inc. (GHAA, Inc.). GHAA is the oldest and largest trade association representing the HMO industry. GHAA represents 75 percent of the 591 HMOs which nationwide enroll more than 34.7 million people.

GHAA has been asked today to comment on trends in the HMO industry, the nature of our participation in the Federal Employees Health Benefits Program (FEHBP), the OPM reform proposal, and the 1991 call letter. The FEHBP represents a very important market for many HMOs, and we appreciate the opportunity to appear before your subcommittee.

For the 1990 contract year there are 300 HMOs serving over 993,000 enrollees. HMOs, known in FEHBP parlance as "comprehensive medical plans" or CMPs, have about 25 percent of all the federal contracts. This represents real and steady growth of HMO participation in FEHBP. In the early 70's, this figure was around 4 percent; in 1987 it was 18 percent.

HMOs, as you know, provide a comprehensive benefit package in exchange for a fixed monthly premium. HMOs provide preventive services, primary care visits, hospitalization, outpatient laboratory, outpatient X-ray, prenatal care, emergency care, home health, mental health, drug and alcohol detoxification, hearing tests, vision tests, physical therapy, inhalation therapy, speech therapy and occupational therapy. In addition to these basic benefits, almost all HMOs also cover pharmacy services, allergy treatment, skilled nursing care, dental services for accidental injuries, drug and alcohol rehabilitation, hospice, podiatry, external prosthetics and durable medical benefits. Virtually all established HMOs provide unlimited hospital services.

All plans covered primary care visits with no limit on the number of appointments. While about 50 percent of the HMOs required a copayment for primary care visits, it was usually in the $3-$5 range. Preventive services are covered by virtually all established plans, usually without cost sharing. These services include well-baby care, Pap tests, mammography (for screening and diagnostic purposes), influenza shots, childhood immunizations, and routine physicals. The average copayment for HMO prescription drug coverage was $3.29. Eighty-two percent cover hospitalization without any patient payment requirement. Not only are HMOs known for providing a comprehensive set of benefits, their cost sharing is very different from that of traditional insurance. Coinsurance is generally low as described above and deductibles are rarely used. These results for HMOs compare favorably with traditional insurance. According to a recent employer survey, conventional benefits in 1988 typically involved a deductible of $100 for individuals and $300 for families, plus 20 percent coinsurance.

As a result of the differences in first dollar coverage between HMOs and traditional insurance, direct comparisons of benefits between indemnity coverage and HMO coverage cannot be readily made. Any consideration of standardization of benefits must take into account these differences.

HMOs are able to keep premiums and coinsurance affordable through "managing care" which assures appropriate care, often in an outpatient setting. Specifically, inpatient utilization rates in HMOs are substantially below the national average. For example in 1987, established HMOs (over three years old) provided 352 inpatient days per 1,000 for enrollees under 65, which contrasts with the national average of 588 days per 1,000. HMO rates for people 65 and older were 1,690 days per 1,000 versus a national average of 3,030.

Overall, inpatient days per 1,000 enrollees for the nation were about 90% higher than for the average established HMO. This reflects national discharge rates that were about 42% higher and a length of stay that was about 34% higher than HMOs.

GHAA believes that HMO participation in the FEHBP has been beneficial for the federal enrollees and for the federal government. In a time when health care costs are escalating and costs are often unpredictable, the very nature of the HMO delivery system has made a contribution. Premiums are set and predictable, cost sharing is minimal so that access to care is enhanced and HMO premiums (both in general and for the FEHBP) have risen more slowly than fee-for-service counterparts - generally half that of traditional insurance in the past few years.

Let me now turn to the question of reform of FEHBP. The question we ask of ourselves is is the program serving the needs of the federal enrollee and is the nature of the program such that it offers HMOs an opportunity to participate in a manner compatible with our delivery system? In our view, the answer to both questions is "yes." Does that mean there aren't problems with the current program? Of course not.

GHAA believes that there are some positive changes that can be made to the program but that a complete overhaul of the system is probably unnecessary and might prove disruptive or even have unintended negative effects.

The focus of any discussion of reform should remain the federal employee and reform should not be viewed as an opportunity to produce cost savings at the expense of the federal enrollee.

Our specific concerns about the OPM reform proposal relate to two changes which directly affect HMOs -- the minimum benefit standard and rating.

Minimum benefit standards and rating changes are being discussed to address risk selection. I'd like to make several comments on the issue before turning to the specific proposal. First, because HMOs offer such a comprehensive benefit package, there is literally "something for everyone" -- from prescription drug coverage with little or in some cases, no copayment, to maternity and well baby care that may cost nothing beyond the regular premium. In fact, HMOs enroll a disproportionate share of women between the ages of 15-44, women who deliberately enroll in an HMO to receive maternity and well baby care. This too is adverse selection.

As far as annuitant enrollment, it is true that the majority of these individuals have been clustered in the high option of the government-wide plans. When most of these people were younger and were active employees, their choice of health plans did not include many HMOs. While this is no longer the case, change may be something these people are unwilling to undertake. The HMO industry has found that the elderly who have long established relationships with their own physicians are least likely to change enrollments to HMOs.

It is worth noting however, that among the HMOs which have participated in the FEHBP the longest, their percentage enrollment of annuitants is representative of the FEHBP annuitant population. A table presented in the report prepared by Towers, Perrin, Forster and Crosby (TPF&C) for OPM showed that Kaiser North and Kaiser South had 33 percent and 28 percent of annuitants of their total FEHBP enrollment, respectively. In my own plan, with over

62,000 federal enrollees, almost 30 percent are annuitants. Based on satisfaction surveys conducted by some of our plans, we have found that once these enrollees have stayed in the HMO for an initial period, they tend to remain, so that over time the HMO enrollees "age-in" and become older and sicker. This is also known as regression to the mean. As the HMO share of the federal market increases, this is intensified.

GHAA supports the concept of a minimum benefit package with the caveat described earlier. Because HMO first dollar coverage is so different than the indemnity coverage under FEHBP, requiring identical benefit packages between HMOs and the fee-for-service plans may not be appropriate.

In addition, many of the HMOs which participate in FEHBP are federally qualified which means they are required by federal law to offer minimum benefits which are quite comprehensive. These requirements also establish limits on the amount of coinsurance an HMO may charge. We would request that any changes in minimum benefit levels take into consideration the requirements of the federal HMO Act. Therefore the OPM propposal that establishes separate supplemental benefits should not apply to HMOs because their comprehensive benefit packages include most of these supplemental benefits.

GHAA has put together an industry working group on the issue of a separate minimum benefit standard and we would be happy to work with you Senator to develop an appropriate minimum standard benefit package for HMOs which is comparable to the indemnity coverage.

On the issue of rating, GHAA opposes the proposal by OPM for a "cross subsidy" of rates. Although they give little detail, OPM suggests that HMO rates be "adjusted downward" or that they add a "premium loading to create a flow of funds to the indemnity plans."

First of all, this proposal completely ignores how the current process works. HMOs use community rating which means that their rates are already adjusted for population characteristics. There is no need for a second adjustment to rates.

Secondly, OPM's assumption is that all HMOs have lower utilizers and that OPM should adjust the government's contribution to HMOs based solely on OPM's data on the age and sex composition of the HMO's enrollment. Age and sex have not been found to be good predictors of health status and may not be related to costs.

To address OPM's concerns about this issue we suggest following the HMO industry practices in rating. HMOs currently use three methods of rating - community rating, community rating by class (CRC) and adjusted community rating (ACR). ACR is a new type of rating added by the HMO Act Amendments of 1988 to respond to employer pressure for a system that could use characteristics of a specific employer group, including actual experience. However, the rate is still prospectively determined. No retrospective adjustments are made at the end of the year.

GHAA has been working with OPM to adapt the Federal Employees Health Benefits Acquisition Regulations (FEHBARs) to the flexibility now permitted.

Allowing full use of ACR will allow the HMO to take into account the actual experience of their federal enrollees, if the HMO selects this method of rating.

To help address the problems associated with Medicare eligible beneficiaries, GHAA has two recommendations. First, there should be a separate Medigap option available. HMOs should be able to offer a Medigap option on the same basis as indemnity carriers. Secondly, Medicare eligibles should be able to enroll under a Medicare TEFRA risk contract without penalty. Today, under TEFRA, the Health Care Financing Administration (HCFA) contracts with 90 HMOs who enroll more than 1 million Medicare beneficiaries. Under the risk program, HMOs provide a benefit package that includes benefits required under Medicare, plus supplemental benefits. Most HMOs charge a monthly premium which "buys out" all of the deductibles and coinsurance under Medicare Part A and B. The individual must still pay the Part B premium however.

Currently, the FEHBP and the Medicare risk program are completely incompatible. If an annuitant would opt to enroll in the HMO Medicare risk program, they would need to disenroll from FEHBP in order to avoid pay for duplicate benefits and would be ineligible to re-enroll. OPM and HCFA have discussed this issue, but as yet without a satisfactory resolution. We would like to work with the subcommittee to correct this problem.

There are two longstanding problem areas in the FEHB Program where we have sought reform through administrative processes: one is the scope and detail of health benefits brochures; the other is reconciliation of federal enrollment numbers with the premium payments made by OPM and the various federal agencies.

In the case of the brochure, "standardization" of brochure language makes consumer differentiation between HMOs in terms of their service protocols, health center locations and provider networks extremely difficult. OPM has also reduced the number of pages permitted for brochure copy to one half of that allowed for indemnity plans.

The reconciliation problem is a real "bottom line" issue because it appears that there is no mandate, and therefore no system, for correlating enrollments with agency premium contributions and payroll deductions. It is impossible to determine either who you are being paid for or if you are being paid for a given enrollee. Most HMOs believe that they have in fact more Federal members that they receive payments for. This is such a basic problem, we are concerned about the administrative complexity required of moving to a national self-insured program. Both of these issues may now warrant legislative attention given the lack of any progress toward administrative relief.

We have also been asked to comment on the 1991 call letter. Although we do not yet have a formal response from our members on switching to a fiscal year basis with the attendant change in open season timing, we are concerned about three aspects of the proposed change. First, as a matter of principle we oppose not permitting new HMOs to apply to the program during part of the 21 month period. We are also concerned about the "adjustment" to rates which will be made.

Mr. Chairman once again let me thank you for the opportunity to share our views today. We believe that the health care marketplace is moving in the direction of managed care. We believe that HMO participation in FEHBP has been valuable for the federal enrollee and for the federal government as employer in providing comprehensive quality and cost effective health care. We know that many others agree with us given the outlines of reform proposals presented by Congress and OPM. We would like to work with you as the work proceeds.

Responses to Questions Posed to
Robert Pfotenhauer, CEO, Group Health Association

1. How are HMO's able to compete for enrollees in the federal health insurance plan?

Answer: Over the past few years, HMO's have increased enrollment dramatically versus traditional insurance plans. HMO's have become much more accepted by the general population. Combined with a more comprehensive benefit package and substantially lower out-of-pocket costs, Federal employees have begun flocking to HMO's versus the more established traditional plans. Growth would most likely be even faster except for the issue of physician choice where traditional insurers still have an advantage. However, as their premiums continue escalating, even employees with an established physician relationship will begin to consider HMO alternatives from a cost/value perspective. HMO premiums in FEHBP, and in general, have risen much more slowly than the premiums for indemnity insurance.

2. Prescription drug prices are rapidly increasing, yet the drug industry does not appear to me to be doing their part in containing health costs. What does Group Health Association do to control the price of prescription drugs for its members?

Answer: Group Health Association manages the cost of outpatient prescriptions and clinical supplies through prudent acquisition and product utilization review. Large volume allows us to participate in group purchasing contracts or buying groups to achieve lower prices. These savings are retained by use of inventory management and centralized distribution systems. The final outcome of these processes -- the member's prescription drug benefit, is again managed by employing formularies, excluding experimental agents or drugs of questionable therapeutic value and by regulating quantities to avoid waste.

GHA's practice is consistent with that of the HMO industry. The attached excerpt from the forthcoming GHAA Annual Industry Survey and a Fall 1989 Health Affairs article describe in detail HMO industry practice with regard to prescription drugs.

It is unclear to me what type of mental health and substance abuse benefits OPM plans to offer under a reformed insurance plan. Given the extent of the drug abuse problem in this country, especially among our youth, what kind of mental health and substance abuse coverage does your HMO offer to enrollees?

nswer: GHA's mental health and substance abuse benefits are as follows:

Our basic mental health benefit package is identical to that which is specified in the Federal HMO Act's basic health services, i.e., 20 outpatient visits for mental health crisis intervention or for conditions which are amenable to significant improvement with short-term therapy. FEHBP Standard Option enrollees are charged a $10 copayment/visit; members with High Option have no copayment. Members are provided with full coverage for 30 days of acute inpatient mental health care services per year following payment of a $200 and $100 inpatient copayment per year for Standard and High Option, respectively.

As consistent with federal law, our plan provides unlimited coverage for substance abuse detoxification, i.e., the treatment of acute medical aspects of substance abuse detoxification, including alcoholism and other chemical dependencies. Outpatient copayments are as indicated above. An additional component of our substance abuse benefit package provides coverage for individual and group therapy rehabilitation services, as well as payment of $80/day for 30 days of inpatient rehabilitation services when deemed medically necessary by a Plan mental health provider.

GHAA is also unclear as to what mental health benefits are being suggested under reform proposals. The GHA response is consistent with general industry practice - OPM requires 20 outpatient visits and 30 inpatient days. However, some states have mandated additional mental health benefits which the HMO may provide to the federal enrollee.

In terms of substance abuse, the federal HMO Act requires as part of the required basic health services, medical treatment and referral services (including referral services to ancillary services) for the abuse of or addiction to alcohol and drugs. Alcohol and drug rehabilitation services are also provided - the average visit limit is 32.8 with a range of 20-90 visits, according to GHAA's HMO Industry Profile - 1989 Edition, Volume 1.

GHAA's Federal Employees Health Benefits Subcommittee has formed a Benefits Workgroup that is looking at mental health and substance abuse benefits under this program to discuss, what, if any, changes might be appropriate. Currently under discussion is treating mental and substance abuse benefits separately.

4. Can you explain how HMO's price their policies and why it might be that the Federal government is paying more for a less comprehensive set of benefits?

Answer: HMO's base their premiums on benefits offered, the anticipated costs that must be covered for the following year, overall demographic/utilization characteristics of all members insured through the given plan, and specific characteristics of individual groups. In the case of the Federal government versus a local county government, if an HMO is federally qualified, the same rating methodology must be used for both groups. This would preclude a higher premium for the federal account if the benefit package was actually less comprehensive. However, when taking into account demographic characteristics and utilization experience of both groups (if applicable, based on the use of adjusted community rating), the scenario depicted could occur but it would be driven by population differences not benefits.

PHARMACY BENEFITS IN HMOs, 1989

The following information is an excerpt from GHAA's forthcoming HMO Industry Profile (1990 Edition), volume 1 "Benefits, Premiums, and Market Structure in 1989".[1] The results are based on GHAA's Annual HMO Industry Survey. Unless otherwise noted, results are for plans over three years old ("established plans"). Survey respondents include 63% of all established plans (303 plans in all) with 75% of the total enrollment in established plans (25.1 million enrollees).

HIGHLIGHTS

- Almost all plans (93.3%) covering pharmacy services in their best selling package did so with no dollar limit. Eighty-eight percent required some patient cost sharing. Most typically, this was a copayment which tended to be $3-$5. Twelve percent used a deductible; the most common deductible was $50. Pharmacy benefits are the only HMO benefit where deductibles are used to any meaningful extent.

- On average, 87.5% of a plan's total enrollment enrollees had pharmacy coverage. In providing these benefits, 12.8% of plans covered over the counter drugs, and 83.7% birth control pill and devices in at least one of their packages. In-house pharmacies were more likely in plans organized around large group practices. Seventy-seven percent of group and staff model plans had in-house pharmacies; only 9.8% of networks or IPAs did.

- The two most common approaches for use of generic drugs were to limit coverage to generics unless a physician specially requested otherwise or to require greater patient payment for brand names than for generics. Twenty-eight percent of plans did not vary coverage for brand names and generics.

- Formularies were used by about half the plans. Only 19.5% of group and staff model plans made no use of a formulary compared with 62.6% of networks and IPAs. The majority of plans restricting coverage to drugs on the formulary allowed for exceptions.

- Therapeutic substitution by a pharmacist was allowed by slightly less than half of the plans. Therapeutic substitution most commonly was at the pharmacist's discretion within established parameters or upon consultation with a physician.

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[1] The excerpt provided is preliminary. Some minor changes are possible in the final report. For further information, contact Marsha Gold, Sc.D., Research and Analysis Director, GHAA, 1129 20th Street NW, Suite 600, Washington, D.C. 20036, 202-778-3249.

Overview of Pharmacy Benefits in Best Selling Package

Pharmacy benefits were included in the best selling benefit package of 95.4% of plans. A minority of plans (6.7%) applied a dollar limit to these benefits; these limits ranged from $300 to $100,000 but were $3,000 or less for all but two of the plans using dollar limits. Twenty-eight percent of plans noted other limits. The most common limit was a restriction to a 30 day supply, 100 unit dose or similar restriction. Some plans noted differences in outpatient and inpatient coverage. Others noted the use of generics or formularies; these practices are discussed in more detail in the next section which covers the delivery of pharmacy benefits.

Most plans (87.9%) covering pharmacy benefits required some patient payment. Eighty-two percent required a fixed dollar copayment which averaged $3.90, with a range of $1-$10. The most common copayments were $3.00 or $5.00, used by 32.5% and 33.0% respectively of plans using copayments. Seven percent of plans with copayments had copayments greater than $5.00. Nine percent of plans applied coinsurance requirements to pharmacy benefits, with an average requirement of 24.3% and range of 10% to 50%.

Pharmacy benefits were the only benefit examined where deductibles were used to any meaningful extent. Twelve percent of plans used a deductible, with these ranging from $2 to $500. The majority of deductibles used were $50 (56.7%), with a $100 deductible used next most commonly (20.0%). Seventeen percent of plans using deductibles set them at $5.00 or less; in all likelihood these are per prescription deductibles as contrasted with calendar year deductibles.

Delivery of Pharmacy Benefits by HMOs

Because HMOs integrate financing and delivery of care, they have had more experience in handling pharmacy benefits than traditional insurers and more incentive to manage delivery effectively. As pharmacy costs have risen, there has been growing interest in how HMOs handle pharmacy benefits. To improve information in this area, this year's survey included a number of questions on pharmacy benefits delivery as a special topic.[2]

Virtually all established plans covered prescribed drugs in at least one of their benefit packages in 1989 (98.3%). On average,

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[2]. For readers interested in pharmacy benefits within HMOs, see also Marsha Gold et al "Pharmacy Benefits in Health Maintenance Organizations" Health Affairs 8: 182-190, Fall 1989. This article is based on results from a survey of a random sample of GHAA member plans in mid 1989.

87.5% of a plan's enrollees were covered. Ninety percent of enrollees were covered in all but 35.5% of plans; 98% or more of all enrollees were covered in 40% of plans (Figure 3). All but 34.5% of plans offered more than one pharmacy benefit package. Twenty-one percent offered two packages, 17.4% three, and 27.0% four or more. Prior research has indicated that pharmacy benefits were most likely offered as riders rather than included as part of the basic benefit package.[3] In providing pharmacy benefits, 12.8% of plans covered over the counter drugs in at least one of their pharmacy benefit packages; 83.7% covered birth control pills or devices.

The two major methods used by HMOs in delivering pharmacy benefits are in-house pharmacies and contracted pharmacies, with the later administered either directly or indirectly through a third party administrator. Contract arrangements also are commonly used as an adjunct to in-house pharmacies, particularly for smaller plans.[4] In house pharmacies were more likely in plans organized around large group practices (Figure 4). Seventy-seven percent of group and staff model plans used in-house pharmacies while only 9.8% of network or IPA model plans did. Although only 31.4% of plans used an in-house pharmacy in delivering pharmacy benefits, a greater percentage of enrollees were served by these pharmacies because plans with in-house pharmacies tend to be larger than others. There were 12.6 million enrollees in the plans which indicated use of an in-house pharmacy; this represents over half (53.2%) of the total enrollment of responding established plans.

There has been considerable interest in the features HMOs use in structuring pharmacy benefits. HMO practices with regard to generic drugs, formularies, and therapeutic substitution are summarized in Exhibit 3. Because the extent of these practices has historically been influenced by the inclusion of an in-house pharmacy, separate profiles are provided for group and staff model plans, versus network and IPA models.

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[3]. Gold et al, ibid.

[4]. Gold et al, ibid. This article also describes the variety of methods used in delivering pharmacy benefits and the percentage of prescriptions filled on average using each of these methods by plans of different model types. Note that the Annual HMO Industry Survey responses reported on in this edition of the HMO Industry Profile also indicate that 16.2% of plans made some use of mail order pharmacies in 1989, 8.5% made some use of indemnity arrangements, and 39.2% used some form of card system in administering the pharmacy benefit dispensing arrangements. The inclusion of some form of mail order arrangement increased by plan size, with 32.8% of plans with 100,000 enrollees or more making some use of this approach. Prior research has indicated, however, that only a small percentage of prescriptions are filled using this type of arrangement (Gold et al, ibid).

Most HMOs included some use of generic drugs in their benefit structure although the form this took varied by plan. The two most common approaches for use of generic drugs were to limit coverage to generics unless a physician specially requested otherwise or to require greater patient payment for brand names than for generics.[5] Network and IPA model plans were twice as likely to use differential cost sharing as others. Twenty-eight percent of plans indicated that coverage did not vary for generic and brand name drugs; this approach was most common for group and staff model plans.

Formularies were used by half of the plans. Formularies were three times as common in group and staff model plans as others. Only 19.5% of group and staff model plans but 62.6% of network and IPA plans indicated that they made no use of a formulary. Restrictive formularies--where coverage is restricted to pharmaceuticals on the formulary-- were more commonly used than non-restrictive formularies although both were common. The majority of plans restricting coverage to drugs on the formulary allowed for exceptions. Formularies generally were established by physicians, pharmacists and sometimes other care providers. This generally was accomplished through a Pharmacy and Therapeutics (P&T) Committee. A few plans noted that state Medicaid agency formularies were used.

Therapeutic substitution by a pharmacist was allowed by slightly less than half of the plans; 43.7% of group and staff model plans did not allow therapeutic substitution while 59.0% of networks and IPAs did not allow it. Therapeutic substitution most commonly was at pharmacist's discretion within established parameters or upon consultation with the physician. Based on plans' open ended responses, it appears that these practices are closely related to formulary practices, with allowed interchanges developed by the P&T Committee or between physicians and the pharmacist. These practices also are regulated by state law. In addition, some of the plans using therapeutic substitution limited it to a small number of interchanges.

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[5]. In addition , some plans said they used "other" generic arrangements and indicated that they required higher charges for brand names regardless of whether a physician recommended the drug.

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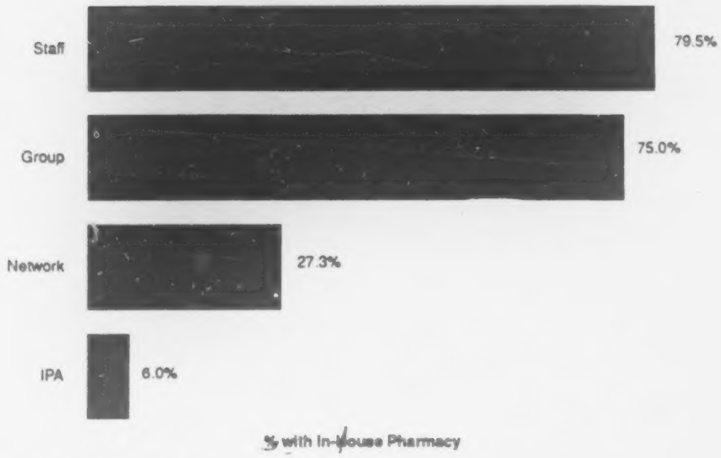
Figure 4

Use of an In-House Pharmacy By Plans of Different Model Types, Plans over Three Years Old, 1989



SOURCE: GHAA's Annual HMO Industry Survey

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Exhibit 3
Treatment of Various Cost Containment Features
in Delivering Pharmacy Benefits by Model Type,
Plans Over Three Years Old, 1989

Type of Measure	All Plans	Group Staff Models	Network IPA Models
GENERIC DRUGS			
1. Coverage limited to generics when available	5.4%	7.9%	4.3%
2. Above, unless physician specifically requests a brand name	29.3%	28.1%	29.8%
3. Generics and brand names covered but patient pays more for brand names unless physician specifically requests it	30.3%	19.1%	35.1%
4. Same coverage for generics and brand names	28.3%	39.3%	23.6%
5. Other	6.7%	5.6%	7.2%
(Number of Plans)	(297)	(89)	(208)
FORMULARIES			
1. Coverage restricted to formulary	10.9%	12.6%	10.2%
2. Coverage restricted to formulary but exceptions allowed	16.7%	29.9%	11.2%
3. A formulary exists, but coverage is not restricted to it	20.1%	35.6%	13.6%
4. No formulary	49.8%	19.5%	62.6%
5. Other	2.4%	2.3%	2.4%
(Number of Plans)	(293)	(87)	(206)
THERAPEUTIC SUBSTITUTION BY PHARMACISTS			
1. Allowed, at pharmacist's discretion within established parameters	16.4%	23.0%	13.5%
2. Allowed by pharmacist upon consultation with physician	25.4%	29.9%	23.5%
3. Not allowed	54.4%	43.7%	59.0%
4. Other	3.8%	3.4%	4.0%
(Number of plans)	(287)	(87)	(200)

Source: GHAA's Annual HMO Industry Survey

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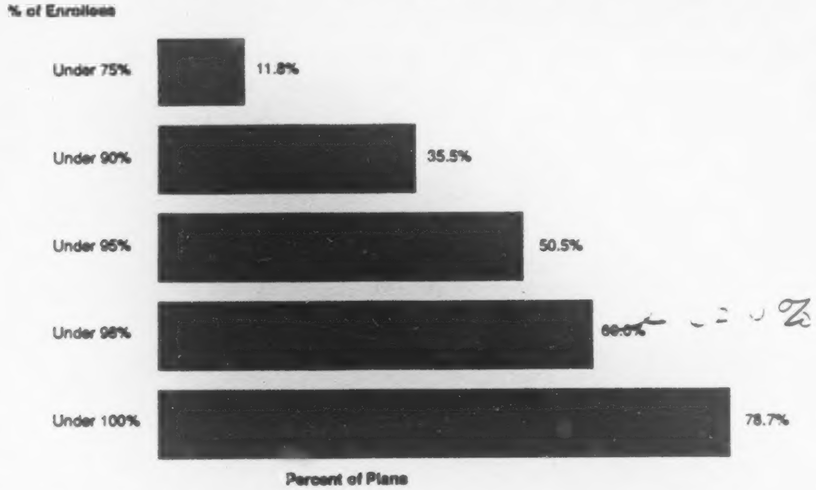
Figure 3

Percent of Enrollees Covered for Pharmacy Benefits, Cumulative Percent of Plans, Plans Over Three Years Old, 1989



SOURCE: GHAA's Annual HMO Industry Survey

DataWatch

Pharmacy Benefits In Health Maintenance Organizations

by Marsha Gold, Mark Joffe, Timothy L. Kennedy, and Anthony M. Tucker

The passage of the Medicare Catastrophic Coverage Act of 1988, combined with the introduction of some high-cost pharmaceuticals in recent years, has focused attention on pharmacy benefits. Pharmacy and related expenditures accounted for $34 billion nationally in 1987.[1] Although these represent only 7.7 percent of personal health care spending in the United States, the fact that consumers directly pay over three-quarters of these expenditures for prescription and nonprescription drugs gives them added prominence.[2]

In this DataWatch, we examine how health maintenance organizations (HMOs) structure their pharmacy benefits. Because HMOs integrate financing and delivery of care, they have had more experience in handling pharmacy benefits than traditional insurers and more incentive to manage delivery effectively. As HMOs' market share increases, interest grows in understanding HMO pharmacy benefits, their spillover effects on the rest of the health care system, and benefits from the HMO experience for other forms of health care delivery. Since implementation of the pharmaceutical provisions of Medicare's catastrophic legislation covers beneficiaries served by HMOs, federal administrators also want to understand and accommodate HMO practice.

Because knowledge of HMO pharmacy benefits is limited and most studies are out of date or not in the public domain, the Group Health Association of America (GHAA) conducted a survey of a sample of its membership in summer 1989 exclusively on pharmacy benefits.[3] GHAA is the oldest and largest national association representing prepaid managed care systems. Here we draw on the results of this sample survey as well as GHAA's ongoing Annual HMO Industry Surveys.[4]

Marsha Gold is director, Research and Analysis, for the Group Health Association of America, Inc. (GHAA). Mark Joffe until recently was GHAA associate counsel; currently, he is an associate with Alan M. Gnessin, P.C., a law firm known for its work in managed care. Timothy Kennedy of ICM, a GHAA contractor, conducted the 1989 telephone survey and preliminary data analyses. Anthony Tucker is a senior research associate at GHAA.

In June and July 1989, we surveyed a random sample of GHAA member plans about prescription drug benefits, pharmacy dispensing arrangements, data systems in place, cost containment practices, and several areas relevant to the implementation of Medicare catastrophic drug benefits. The survey was sent to a proportionately stratified random sample of thirty-nine GHAA member plans, with the responses obtained in a follow-up telephone interview with the person designated by the chief executive officer (CEO) as best able to respond. Because we expected practices to vary by model type and size, we randomly selected within the group/staff and network/individual practice association (IPA) members by four size categories. All but one plan agreed to participate in the survey; a similar plan was substituted through random selection. Surveyed plans had 4.04 million enrollees as of December 31, 1988, or 12.4 percent of total HMO enrollment. Sixty-four percent of plans were IPAs or networks; 36 percent were group- or staff-model plans. Fifteen percent had 100,000 or more enrollees; 39 percent had under 20,000 enrollees as of December 31, 1988. The distribution of surveyed plans closely resembles the industry. Older and larger plans are somewhat overrepresented, and IPAs underrepresented. Because sampling was based on plans rather than enrollment to reflect the organizations in the industry, the profile does not necessarily reflect the experience of enrollees, who are disproportionately enrolled in older, larger plans (typically group or staff models).[5]

Pharmacy Benefits In HMOs

According to GHAA's HMO Industry Survey, almost all plans (93.9 percent) cover pharmaceuticals in their most commonly selected benefit package, either in the core package or in a rider typically purchased with that package. Most plans (88 percent) require some patient payment, typically a fixed-dollar copayment per prescription or refill; a three-dollar copayment is most common. Deductibles and coinsurance are less common in HMOs (15 percent and 9 percent of plans, respectively). Twenty-seven percent of the plans report some limit on the extent of the benefit; limits usually are not based on expenditures but refer to the structure of benefit delivery. The most common limit noted is a restriction on the amount supplied per month or prescription to a thirty-day, one hundred-unit dose or similar supply.

HMO pharmacy benefits in 1988 were similar to those offered in 1986, but the percentage of plans covering the benefit in the best-selling package increased from 1986 to 1988, and copayment levels increased (from a mean of $2.78 to $3.29). The percentage of plans using pharmacy deductibles or coinsurance also increased, although the amount was small and could be explained by differences in responding plans.[6]

HMO Pharmacy Survey. According to GHAA's 1989 HMO Pharmacy Survey, 23 percent of plans covered prescription drugs within the basic benefit package, 74 percent as a rider to the package, and 3 percent (one plan) not at all. Even though pharmacy benefits are typically purchased as a rider, on average, 85.7 percent of plan enrollees were covered by the benefit.[7] Two-thirds of plans had 90 percent or more of their enrollees with pharmacy coverage, and 36.8 percent had over 95 percent of their enrollees covered. To deliver this coverage, HMOs often develop multiple pharmacy benefit options for purchase. When all options are considered, it appears that virtually all plans (97 percent) have some experience with using fixed-dollar copayments.

In structuring pharmacy benefits, HMOs typically limit drug coverage: 76 percent limited experimental drugs; 73 percent, over-the-counter drugs; and 63 percent, birth control devices. Most likely, these are plans that exclude by name such coverage, with other plans providing coverage in selected circumstances or conditions. In addition, 42 percent of plans limited coverage for azidothymidine (AZT) for acquired immunodeficiency syndrome (AIDS). It is not possible to tell from the survey if these limits refer to more experimental uses, although this seems likely.

Pharmacy benefits under Medicare contracts. Of the surveyed plans, 30 percent had Medicare risk contracts and 19 percent had Medicare cost contracts; four plans had both.[8] Although reports issued by the Office of Prepaid Health Care of the Health Care Financing Administration (HCFA) indicate that only 29 percent of all Medicare risk contractors offer outpatient drug coverage under their basic option package, 73 percent of risk contractors responding to our survey (and 71 percent of cost contractors) said they provided pharmacy benefits to Medicare enrollees.[9] This disparity is attributable largely to definitional differences.[10] If plans not included in HCFA's count are removed, 36 percent of surveyed risk contractors (and 28 percent of cost contractors) would be considered to cover pharmacy benefits for Medicare contract enrollees.

When HMOs cover pharmacy benefits for the Medicare population, they tend to use the same benefit structures that they use for their commercially enrolled populations. Half of the risk contractors covering pharmacy benefits employed identical cost sharing to that used for commercial enrollees; the remaining plans differed largely in the use or amount of copayments, with no clear patterns. In total, 63 percent of surveyed risk contractors providing Medicare pharmacy benefits used a copayment that averaged $3.40; 25 percent used a deductible (averaging $44.50), and one applied 50 percent coinsurance.

HMO Pharmacy Characteristics

Dispensing arrangements. HMOs use three major dispensing arrangements for pharmacy benefits: in-house pharmacies, direct contract pharmacies, and indirect contract pharmacies through third-party administrators. Dispensing arrangements differ substantially by HMO model type (Exhibit 1). Most group- and staff-model plans (and all such plans with 100,000 enrollees or more) used an in-house pharmacy. These are used almost exclusively for members; on average, only 1.4 percent of prescriptions were for nonenrollees, and half the plans served no nonmembers.

In group- and staff-model plans with 100,000 enrollees or more, the in-house pharmacy was used almost exclusively, with small percentages of prescriptions filled by noncontracted pharmacies. Group- and staff-model plans with under 100,000 enrollees sometimes used pharmacies under direct contract or (less likely) under contract through a third-party administrator instead of an in-house pharmacy or along with it. Because of the large share of HMO enrollees in plans with over 100,000 enrollees, the 48 percent of the average group/staff-model plan prescriptions filled in house understates considerably the role these pharmacies play.

Network and IPA plans did not have in-house pharmacies and instead used pharmacies either under direct contract or under contract through a third-party administrator. Larger plans were considerably more likely to contract with pharmacies directly; smaller plans were about evenly split among the two strategies. Although 29 percent of all surveyed plans used

Exhibit 1
Profile Of HMO Pharmacy Dispensing Practices, Selected Measures By Model Type, 1989

Method of pharmacy dispensing	Percent using			Percent using for more than half of prescriptions[a]			Mean percent of prescriptions dispensed		
	All plans	Group/ staff	Network/ IPA	All plans[b]	Group/ staff[b]	Network/ IPA[b]	All plans[b]	Group/ staff[b]	Network/ IPA[b]
In-house	26%	71%	0%	16%	43%	0%	18%	48%	0%
Direct contract	58	50	63	47	36	54	48	38	55
Indirect contract (third-party administrator)	29	14	38	29	14	38	28	11	37
Noncontract	29	29	29	3	0	4	4	2	5
Mail-order	11	14	8	3	0	4	3	2	4

Source: GHAA 1989 HMO Pharmacy Survey.

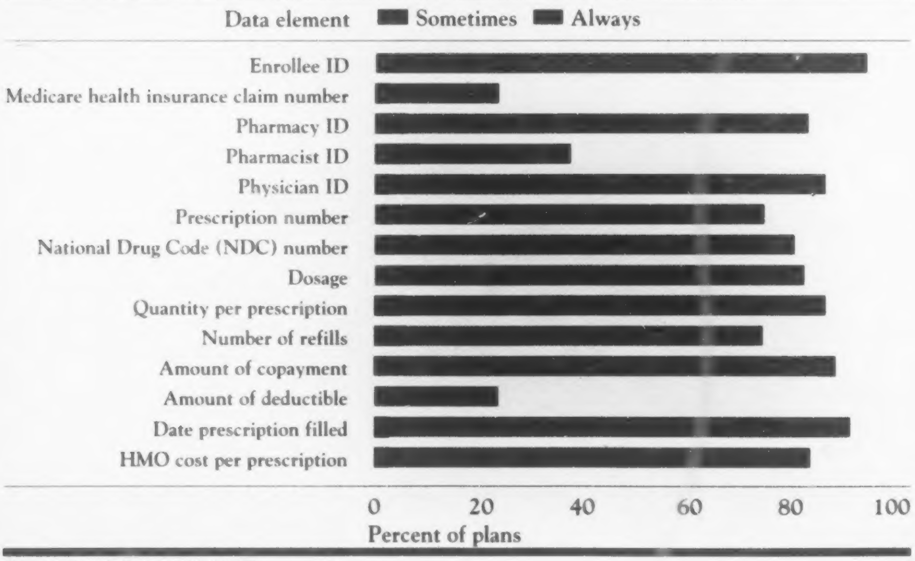
[a] One plan of the group/staff model did not have a majority method. This plan accounts for 3 percent of the all plan total and 7 percent of the group/staff total.

[b] Percentages do not necessarily add to 100 percent because of rounding.

noncontract pharmacies, these almost always were responsible for a small share of the HMO's prescriptions. Mail-order pharmacies also filled a more specialized role in pharmacy delivery.

Pharmacy data elements. Exhibit 2 summarizes the pharmacy-related data elements in HMO systems, with a focus on elements relevant to the Medicare catastrophic benefits.[11] Data collection practices vary across the industry. Although most plans included the physician identification number, particularly in group- and staff-model plans this may not be the Drug Enforcement Agency number. HMOs with in-house pharmacies were more likely to capture the pharmacist identification number than other plans. A minority of plans appeared to collect the Medicare health insurance claim number, although some plans have indicated to us informally that they could provide this information. Capacity to track deductibles was less likely to exist because HMO benefits tend not to include them. Also, while 75 percent of plans said data elements are routinely available in computer-readable form, this was less likely in smaller plans and those without in-house pharmacies. Over half (58 percent) of HMOs surveyed maintained a prescription drug patient profile system. Profiling systems were particularly likely in plans with in-house pharmacies, in group- or staff-model plans, and plans with 50,000 or more members.

Exhibit 2
Pharmacy Elements Maintained In HMO Information Systems, 1989



Source: GHAA 1989 HMO Pharmacy Survey.
Note: Includes systems maintained by any third-party contractors.

Cost containment strategies. Many cost containment strategies are standard practice in the majority of HMOs (Exhibit 3). Drug utilization review is the most common practice (76 percent of plans). In most instances, the target for review is specific drugs (93 percent) or specific physicians or physician groups (86 percent). Plans with in-house pharmacies also are likely to target specific diagnoses (78 percent). Forty-five percent of plans target specific pharmacies. Mandatory generics and formularies are used in 60 percent and 55 percent of plans, respectively. Higher cost for brand-name or nonformulary drugs, preauthorization requirements, and therapeutic substitution protocols also are used. The cost containment measures in use vary by plan model type, which may in part reflect the use of in-house pharmacies in most group- and staff-model plans.

Some HMOs also use financial incentives for providers to encourage cost-effective prescribing. Eighteen percent of plans placed physicians financially at risk for prescription drug costs. Twenty-nine percent of group- and staff-model plans held physicians collectively at risk; most likely these are group-model plans, which pay the physician group as a whole a capitation fee for medical care. Thirteen percent of network and IPA plans placed physicians at some risk; all of these shared risk among physicians as a group, and two-thirds also held physicians individually at risk for prescription drug costs. In addition, 15 percent of surveyed plans held contracted pharmacies at risk for prescription drug use.

It appears that many cost containment practices are diffusing across the HMO industry. As one example, Exhibit 4 shows the structure of formularies in place in HMOs and plans' expectations for change.

Concern over the cost of pharmacy benefits appears high in HMOs, although this was not specifically addressed in the survey. In addition to formulary changes, 63 percent of plans envisioned instituting or raising their pharmacy copayment over the next two years, and 55 percent

Exhibit 3

Use Of Selected Pharmacy Cost Containment Measures In HMOs, By Model Type, 1989

	Percent of plans using		
Cost containment measure	**All plans**	**Group/staff**	**Network/IPA**
Drug utilization review	76%	86%	71%
Mandatory generics	61	71	54
Formulary	55	86	38
Higher cost for brand names or nonformularies	43	29	52
Preauthorization	38	15	50
Therapeutic substitution	36	57	23

Source: GHAA 1989 HMO Pharmacy Survey.

Exhibit 4
Use Of Drug Formularies By HMOs, 1989

Current formulary practice	All plans	Staff/group	Network/IPA
No formulary	45%	14%	63%
Nonrestrictive formulary	13	14	13
Exceptions[a]	37	64	21
Restrictive formulary[b]	5	7	4
Anticipated formulary activity			
Add formulary (if none)	65	100	60
Better enforce existing formulary	81	75	89

Source: GHAA 1989 HMO Pharmacy Survey.

[a] Coverage restricted to the formulary, but exceptions are allowed.

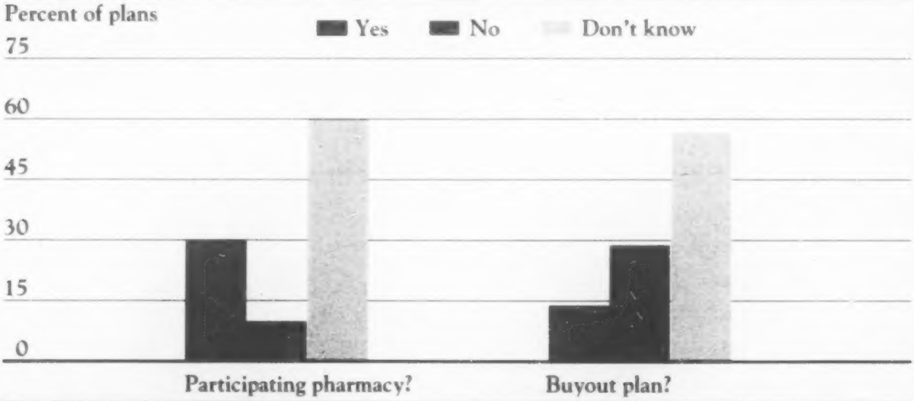
[b] Coverage restricted to the formulary except for emergencies.

envisioned deleting certain drugs from coverage.

HMO Plans For Medicare Catastrophic Implementation

Most HMOs are uncertain about how they will respond to the implementation of pharmacy benefits under the Medicare catastrophic legislation (Exhibit 5). Under the legislation, HMOs with in-house pharmacies must decide if they will be participating pharmacies. An HMO may "participate" to gain access to the automated bill-processing system that HCFA is establishing. Although 30 percent of plans with in-house pharmacies said they intend to participate and 10 percent indicated they would not, the remaining 60 percent were still uncertain.

Exhibit 5
HMO Plans For Medicare Catastrophic Pharmacy Benefits, 1989



Source: GHAA 1989 HMO Pharmacy Survey.
Note: Percentage based only on plans that face the decision indicated.

Plans are similarly uncertain about whether they will elect to become a "buyout" plan in cases where they have Medicare contracts; 14 percent indicated they would decide to become a buyout plan, 29 percent would not, and 57 percent were undecided. An HMO that becomes a buyout plan is not required to track its enrollees' payments for determining whether the Medicare drug deductible is met. To qualify for the buyout option, a plan's deductible must be less than one-half the Medicare drug deductible for fee-for-service practice. Data processing limitations and administrative burden were viewed as very important considerations by 92 and 83 percent of plans, respectively. However, concerns over adverse selection and market place forces also were each very important factors for 42 percent of plans and somewhat important for 42 percent and 33 percent of plans, respectively. Adverse selection concerns were cited more often by group- and staff-model plans, while competitive market forces were more likely to be cited by networks or IPAs, but the differences are not large. Plans with no in-house pharmacy were more likely than others to consider administrative burden as very important in determining whether to be a buyout plan (100 percent versus 57 percent).

Conclusions

HMOs offer extensive coverage of pharmacy benefits, with only limited out-of-pocket cost sharing by enrollees. Pharmacy coverage for Medicare beneficiaries also appears higher than is suggested by routine HCFA reports, although the difference largely appears driven by the better coverage offered to those Medicare enrollees covered under employer groups rather than through individual enrollment. In total, pharmacy coverage for Medicare beneficiaries is less than for the employed population. On the other hand, cost pressures appear to be causing some plans to raise enrollees' payments for pharmaceuticals or to place some limits on coverage, but to date any impact of these changes on the overall pattern of HMO pharmacy benefits appears small.

The survey was not designed to assess pharmacy expenditures in HMOs and the effectiveness of various pharmacy management and cost containment measures. Yet the breadth and growth of these practices indicate that they are important components of HMO pharmacy benefits and contribute to the comprehensive coverage offered. HMOs also appear to be active in monitoring pharmacy utilization and the potential for adverse interactions among drugs through patient profiling. Studies of the impact of these measures would be useful, as would more in-depth assessment of how the measures are structured and implemented.

When Medicare catastrophic benefits were enacted, a deliberate decision was made to limit the scope of the drug benefit to existing practice and not to mandate widespread use of pharmacy cost containment measures, with the exception of generic drug policies. With costs for the benefit anticipated to exceed initial projections, Congress is now reassessing the benefit.[12] As these discussions ensue, HMO practice provides a useful point of comparison and source of experience.

LuAnn Heinen of Lewin/ICF gave advice on practices and question formulation for the 1989 HMO Pharmacy Survey. Dennis Hodges of the GHAA Department of Research and Analysis was responsible for analysis from the Annual HMO Industry Survey.

NOTES

1. S.W. Letsch, K.R. Levit, and D.R. Waldo, "National Health Expenditures, 1987," *Health Care Financing Review* 10 (Winter 1988): 109–121.
2. Ibid. Note that prescription drugs represent about 61 percent of the total expenditure for drugs and sundries, and that out-of-pocket expenditures are less for prescription than for over-the-counter drugs, although still extensive. K.R. Levit, Health Care Financing Administration, personal communication, August 1989.
3. For existing studies on this topic, see especially A. Zuvekas et al., "Cost Containment in HMO Pharmacies," *GHAA Journal* (Winter 1986): 22–34; A. Zuvekas, L. Heinen, and P.D. Fox, *HMO Outpatient Pharmacy Trends* (Washington, D.C.: Pharmaceutical Manufacturers Association, January 1986); S.J. Miller, "HMO Pharmacy Survey" (Washington, D.C.: Group Health Association of America, December 1984); and B. Shah, "An Overview of Pharmaceutical Cost-Containment Practices in the Managed Care Sector," *Drug Benefit Trends* 1 (February/March 1989): 16–22.
4. For a description of survey methods, see GHAA, *HMO Industry Profile, 1989 ed., Vol. 1: Benefits, Premiums, and Market Structure in 1988* (Washington, D.C.: GHAA, June 1988). Cited statistics refer to plans over three years old.
5. For more detailed methodology, contact the authors at GHAA, 1129 20th Street, NW, Suite 600, Washington, D.C. 20036.
6. See GHAA, *HMO Industry Profile*, for an overview of trends.
7. The plan that offers no prescription drug coverage is omitted in the remainder of the analysis since it provides no prescription benefit.
8. For a description of the kinds of contracting options HMOs have within Medicare, see K.M. Langwell and J.P. Hadley, "Capitation and the Medicare Program: History, Issues and Evidence" *Health Care Financing Review* (1986 Annual Supplement): 9–20.
9. "Monthly Report: TEFRA HMO/CMP Contracts" (Division of Contract Administration, Office of Prepaid Health Care, HCFA, July 1989).
10. Three surveyed risk contractors offered pharmacy benefits but only to group enrollees; a fourth provided a discount benefit for all contract enrollees from participating pharmacies. These plans are excluded from the HCFA counts.
11. This list was drawn up largely in response to HCFA's solicitation of advice concerning the implementation of the bill processing system for drug benefits using electronic point of sale technology (HCFA-RFC-8901-D, 13 October 1988). Elements are not necessarily identical to those being used by HCFA, but cover the major areas of concern.
12. See Congressional Budget Office, "Background Material on the Catastrophic Drug Program," prepared for the Senate Committee on Finance, House Committee on Ways and Means, and House Committee on Energy and Commerce, July 1989.

RESPONSES BY CATHERINE K. AUSTIN
POSED BY THE SUBCOMMITTEE ON FEDERAL SERVICES, POST OFFICE AND CIVIL SERVICE

1. What are the tax implications of a cafeteria benefits program? How much has the State of Maryland lost in state revenues as a result of allowing state employees to use pre-tax dollars for health benefits and dependent care? Has this been a problem?

Response:

The net tax savings to the State of Maryland has averaged $2.7M per year.

2.a. Can you relay some of the most common problems in designing and implementing a cafeteria benefits plan?

Response: Most common challenges:

1. Interpretation of Federal guidelines governing cafeteria plans
2. Employee education
3. State leadership education, i.e., Governor, General Assembly, Cabinet and employee labor organizations

2.b. How are you structured to address these problems?

Reponse:

1. Health Insurance Advisory Council
2. Health Care Coordinator Network
3. Maryland General Assembly, House Committee on Appropriations, Personnel Oversight Subcommittee
4. Consultant

2.c. Do you have adequate flexibility in administering the program?

Response:

Yes, though recent and proposed changes in Federal regulations causing concern.

3. Other than some 85% participation rate, do you have any evidence to show how this program is being received by employees?

Response:

Anecdotal only.

4.a. Did the State of Maryland appropriate additional money to start up its cafeteria benefit plan for State employees?

Response:

No. Program was developed using existing resources.

4.b. Is the total value of the package pegged to a percentage of compensation?

Response:

No.

4.c. Because of increasing health care costs nationwide, are employees finding that they are buying less in benefits over time if premiums are increasing faster than wages?

Response:

Maryland State employees have realized a net increase in disposable income in each of the two years the cafeteria plan has been in operation in spite of increases in the employee's share of benefits in premiums.

5. In your testimony, you state that you have experienced a 52 percent increase in your prescription drug program this past year? Do you have any way of negotiating with drug manufacturers to control the high costs of prescription drugs?

Response:

This approach has not been explored by the State to date.

6. Have you seen an increase in administrative costs associated with your cafeteria benefits program as opposed to the old program?

Response:

Staff has increased; however, cost has been more than offset by savings.

7. Does the State of Maryland provide health insurance benefits to retirees?

Response:

Yes.

QUESTIONS FOR CATHERINE AUSTIN:
MARYLAND OFFICE OF PERSONNEL MANAGEMENT

1. What are the tax implications of a cafeteria benefits program? How much has the State of Maryland lost in state revenues as a result of allowing state employees to use pre-tax dollars for health benefits and dependent care? Has this been a problem?

2. Can you relay some of the most common problems in designing and implementing a cafeteria benefits plan? How are you structured to address these problems? Do you have adequate flexibility in administering the program?

3. Other than some 85% participation rate, do you have any evidence to show how this program is being received by employees?

4. Did the State of Maryland appropriate additional money to start up its cafeteria benefit plan for State employees? Is the total value of the package pegged to a percentage of compensation? Because of increasing health care costs nationwide, are employees finding that they are buying less in benefits over time if premiums are increasing faster than wages?

5. In your testimony, you stated that you have experienced a 52 percent increase in your prescription drug program this past year? Do you have any way of negotiating with drug manufacturers to control the high costs of prescription drugs?

6. Have you seen an increase in administrative costs associated with your cafeteria benefits program as opposed to the old program?

7. Does the State of Maryland provide health insurance benefits to retirees?

American Association for Marriage and Family Therapy

Statement of Mark R. Ginsberg, Ph.D., Executive Director
American Association for Marriage and Family Therapy

Submitted to the
Subcommittee on Federal Services, Post Office and Civil Service
Senate Committee on Governmental Affairs

on OPM's Recommendations for the Reform of
the Federal Employees Health Benefits Program

April 20, 1990

Mr. Chairman and distinguished members of the Subcommittee, on behalf of the American Association for Marriage and Family Therapy, I appreciate having this opportunity to comment on the Office of Personnel Management's (OPM) proposal to reform the Federal Employees Health Benefits Program (FEHBP). With access issues and the rising costs of health care on everyone's mind, you have chosen a propitious time to begin to address the problems which have become apparent in the FEHBP system in recent years.

The American Association for Marriage and Family Therapy (AAMFT) is the national professional association of 17,000 qualified practitioners of marriage and family therapy. The Association promotes family-centered treatment of mental and nervous disorders. The Association also works to increase understanding, research and education in the discipline of marriage and family therapy, and to ensure that public needs for necessary mental health services, including marriage and family therapy, are met by practitioners of the highest quality.

My statement will address only one aspect of the Office of Personnel Management's recommendations to Congress regarding the reform of the Federal Employees Health Benefits Program, that is OPM's omission of any recommendations regarding the range of benefits to be offered under a reorganized FEHBP system. Specifically, our Association is deeply concerned by OPM's omission of a recommendation that a mental health benefit be included as part of all standard and high option plans, including HMO options, to be offered by the FEHBP system.

The National Institute of Mental Health (NIMH) reports that vast numbers of Americans with mental and nervous disorders are not treated for those disorders. As we have learned more about the social and behavioral antecedents of many costly medical illnesses, including heart disease, alcoholism, substance abuse, stress-related health problems, AIDS and other diseases, the services provided by qualified mental health professionals, including marriage and family therapists, increasingly are recognized as essential elements of effective, comprehensive health care coverage.

Furthermore, there is widespread evidence that the appropriate provision of mental health services provides a "cost-offset" or a reduction in other medical utilization. The recognition of a significant cost savings

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of this sort would be extremely beneficial to Congress and OPM in the reform of the FEHBP system.

At the request of Congress, the Office of Personnel Management completed a study in 1986 on expanding freedom-of-choice for non-medical health care providers within the Federal Employees Health Benefits Program. The OPM study affirmed the vast and widely accepted empirical literature in health policy and economics which suggests that a "cost-offset" phenomenon exists for mental health coverage. This phenomenon refers to the fact that the use of traditional and expensive medical services is found to decrease when appropriate mental health services are included within health benefit plans. The provision of mental health services, including marriage and family therapy provided by qualified marriage and family therapists and other qualified mental health professionals, contributes to the "cost-offset" effect. Numerous studies show a decrease from 5% to 80% in medical service use following appropriate and well-managed mental health treatment. In fact, this well documented phenomenon in health benefit plan design and management has been thoroughly researched, with significant support from the Department of Health and Human Services' Alcohol, Drug Abuse and Mental Health Administration, specifically from the National Institute on Mental Health.

The "cost-offset" phenomenon also has been found to exist in studies analyzing data from Federal Employee Health Benefit Program plans. These and other studies have documented that marital stress, separation and divorce have a profound impact on health and medical utilization. For example, it has been found that hospital admissions are generally highest for separated and divorced individuals. In fact, admission rates for the divorced have been reported to be from 6-10 times greater than the rate for married individuals. Evidence also suggests that divorced individuals have the highest hospital admission rates for most diagnostic categories, the highest rate of alcoholism, suicide attempts and four to five times as great a utilization of outpatient psychiatric services as their married counterparts.

Furthermore, it has been reported that almost 50% of those who seek psychiatric help in times of crises have a serious marital or family problem as an etiological or exacerbating factor. Certainly, treatment provided by marriage and family therapists is an essential component of a well-designed health benefit program.

The private sector clearly is recognizing the importance and cost savings which can be realized when a system for attending to employees and dependents' mental health needs is instituted. For example, McDonnell Douglas recently conducted a five-year study of its Employee Assistance Program (EAP). The company discovered decreased absenteeism and turnover among its employees and relatively lower medical costs for both employees and their dependents who were treated within their EAP, as opposed to those treated outside the EAP. The study results indicated an offset value of EAP services for participating employees and their dependents of a total of $5.1 million (in 1988 dollars) over the next three years: $2 million of that total will be saved in employee medical claims; savings on dependent medical claims will account for an additional $2.3 million and absenteeism over the next four years will be reduced by 6,121 days saving $.8 million.

The McDonnell Douglas study also concluded that family members must be included and involved in the EAP program for it to be most effective in the early identification and treatment of mental health problems, including substance abuse, thereby avoiding more expensive treatment after problems were exacerbated. This data demonstrates that a well managed mental health benefit provides for several significant areas of cost savings for employers.

AAMFT also believes that there should not be discrimination in reimbursement among health care providers who deliver similar services covered under a health insurance program. Commonly known as the issue of "freedom-of-choice," there are many indicators that increasing competition among providers who deliver similar services tends to lower fees charged by those various providers in general. In this regard, a report entitled Allied Health Services: Avoiding Crises, published by the National Academy of Science's Institute of Medicine, recommended both that statutory certification of health professions should be considered by states, and that, "Medicare and other third-party payers should accept state title certification as a prerequisite for reimbursement eligibility." Clearly this principle has significant support from various sectors.

OPM noted in its 1986 study that the fear:

> "...of greatly increased benefit utilization and costs... have not been realized....Historically, OPM....along with other major insurance carriers, have argued that mandating coverage of additional categories of providers would lead inevitably to an increase in utilization, and hence drive up program costs....OPM can no longer support this view....We no longer are prepared to argue that should Congress decide to mandate coverage of alternative practitioners, such action would inevitably have serious, deleterious consequences..."

Therefore, in mental health care, AAMFT believes that it is essential that all qualified providers, including Clinical Members of this Association and other state-regulated marriage and family therapists, must be included as core providers in the FEHBP reform plan that will be developed by the Subcommittee.

Conclusion

In its consideration of the challenges and problems posed by the evaluation of the existing FEHBP system, AAMFT recommends that the Subcommittee work to ensure that the following goals are met:

1) Mental health is an integral component of comprehensive health care coverage and must not be relegated to a optional list of benefits offered in a cafeteria plan.

2) Beneficiaries and their families must have access to affordable, necessary health and mental health care services, including marriage and family therapy.

3) The FEHBP system must provide direct recognition and reimbursement — or freedom-of-choice — for highly qualified mental health care providers, including marriage

and family therapists, to ensure that beneficiaries have access to the mental health professional of their choice. Freedom-of-choice enhances competition and is cost-effective.

These recommendations are consistent with developments which are occurring in State law and are representative of current trends within the health care delivery system and the marketplace.

The Federal Employees Health Benefits Program must be designed so that it serves as a model for a progressive federal health care delivery system that will endure for many years, taking into account the changing demographics of our nation, new technologies, etc. Any legislative overhaul of the Program must address not only current needs but also must recognize and affirm, consistent with trends in both health policy and state law, that ALL of its health benefit programs include a well-designed mental health benefit as a required component of coverage, including coverage for necessary marriage and family therapy services provided by qualified marriage and family therapists.

Mr. Chairman, on behalf of the 17,000 members of the American Association for Marriage and Family Therapy, I thank you for your efforts in this area. AAMFT looks forward to continuing our work together, toward the goal of affordable, carefully conceived, well-managed, and accessible health and mental health care for all Federal employees and their dependents.

American
Psychiatric
Association

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April 18, 1990

The Honorable David Pryor
Chairman
Governmental Affairs Subcommittee
on Federal Services, Post Office
& Civil Service
601 Senate Hart Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

As you know, the American Psychiatric Association, a medical specialty society representing over 36,000 psychiatrists nationwide, has been intrinsically involved in issues surrounding mental health benefits in the Federal Employees Health Benefits Program (FEHBP). Unfortunately, discrimination and stigma associated with mental illness -- a vestige of an age-old ignorance -- is dramatically seen in insurance coverage for the treatment of mental and addictive disorders, and the FEHBP is no exception. As you recall, in 1983, OPM in an arbitrary manner, still harboring the suspicion that aberrant behavior is entirely willful, drastically reduced coverage for mental and substance abuse disorders. Subsequently, OPM has issued several call letters calling for no further reductions in mental health coverage and premitted carriers to increase their benefit levels.

To date, no substantial improvement has been made in eliminating discrimination or in providing a responsible benefit level for those federal employees, annuitants and their families suffering from the very real, devastating and crippling effects of mental illness. Yet, the nation has witnessed a dramatic revolution in the science of understanding and treating mental disorders and the interrelated illnesses of alcoholism and drug abuse. We have seen the introductions of tricyclics and MAO inhibitors for the treatment of depression; of neuroleptics for those suffering from psychoses; of clozapine for those unresponsive to other neuroliptics; and chlomipramine for obsessive-compulsive disorders. We have also seen the increasing use of dynamically oriented but time-limited psychotherapy, as well as new techniques of crisis intervention, multiple-family group treatment for families with schizophrenic relatives, new behavioral treatments, and documented proof of the effectiveness of psychotherapy in the treatment of depression.

Mental disorders account for the majority of patients receiving clinical hospital care in the United States, yet research shows that only one-fifth of those identified as having a mental illness are currently under treatment. Hence, our concern regarding FEHBP reform and the OPM proposal which is the subject of your April 20 hearing. It is unclear whether 1) OPM's proposal provides coverage for mental disorders, 2) if indeed there is a benefit, whether it continues to be discriminatory, or 3) who is expected to pay for this medically necessary coverage.

Your commitment to FEHBP enrollees receiving quality health care at an affordable cost is critical to the FEHBP reform movement and we believe that coverage for mental and addictive disorders can and should be a basic nondiscriminatory continuum of care core benefit of any health insurance system.

We greatly appreciate the opportunity to express our concerns as you address the tremendous task of FEHBP reform and hope that as you work to develop a system that is both fair and affordable you will consider the tragic discriminatory financial and emotional burden currently placed on the mentally ill population. We welcome the opportunity of working with you.

Sincerely,

Jay B Cutler

Jay B. Cutler
Special Counsel and Director
Division of Government Relations

cc: Members of the Senate Governmental Affairs Subcommittee on Federal Services, Post Office & Civil Service

STATE OF ARKANSAS
DEPARTMENT OF FINANCE AND ADMINISTRATION
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OFFICE OF
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April 17, 1990

Denise Boerum
c/o Senator David Pryor, Chairman
Subcommittee on Federal Services
Senate Governmental Affairs Committee
Senate Hart 601
Washington, D.C. 20510

Dear Ms. Boerum:

This is in response to your recent request that I present testimony concerning the State of Arkansas' experience in setting up a Cafeteria Benefits Plan for its' employees on April 20, 1990 to the Subcommittee on Federal Services, Post Office, and Civil Service . As we discussed in our telephone conversation on Friday, April 13, I will be unable to attend the hearing, due to commitments in Arkansas concerning implementation of our Cafeteria Benefits Plan.

The State of Arkansas made a decision to implement a Cafeteria Benefits Plan to improve the benefits of state employees. The attached fact sheet describes the components of the Arkansas Cafeteria Benefits Plan.

Again, I regret that I am unable to attend. If I can provide additional information concerning the Arkansas Cafeteria Benefits Plan, please let me know.

Sincerely,

Artee Williams
Artee Williams
State Personnel Administrator

AW/elb

Attachment

AN EQUAL OPPORTUNITY EMPLOYER

NEW BENEFITS CAN SAVE EMPLOYEES MONEY!!

The **Arkansas Cafeteria Plan** (ARCAP) is a major new enhancement the state is adding to your compensation package. Employees of participating agencies can expand their benefits and **save tax dollars**. ARCAP has two separate parts: Premium Conversion and Spending Accounts.

Premium Conversion:

Premium Conversion is TAX-FREE conversion of health and life insurance premiums (State Employees Insurance Plan). That is, employees' share of health and life insurance premium costs are deducted from salary before state, federal, and Social Security taxes. Taxable income decreases as spendable income increases.

Spending Accounts:

Spending Accounts are **tax-free** payroll deductions that **reimburse** out-of-pocket healthcare or day care expenses. A fixed tax-free amount is deducted from each paycheck and directed to the appropriate account, either the Dependent Day Care or the Healthcare Spending Account. Salary spent on these items is not included in your taxable wages reported to the Internal Revenue Service. So, the money you save is not simply tax-deferred, it is **completely tax free! You will never be required to pay taxes on this money**.

This plan year, July 1, 1990 through December 31, 1990, introduces cafeteria style benefits to state employees.

VISTA Management Company will administer the Arkansas Cafeteria Plan. VISTA is a leading cafeteria benefits plan administrator and manages plans for 5 states and 22 school systems.

Over the next several weeks, you will hear more about cafeteria benefits. All eligible employees will be asked to attend presentations where detailed information will be available about how the plan works. **Don't miss out on this money saving opportunity!**

STATEMENT OF

RICHARD E. RUDDICK, VICE PRESIDENT

Federal Employees Health Benefits Plan Division

CNA Insurance Companies

before the

Subcommittee on Federal Services,

Post Office and Civil Service

Committee on Governmental Affairs

United States Senate

April 20, 1990

Mister Chairman and Members of the Subcommittee:

Thank you for providing the CNA Insurance Companies ("CNA") with the opportunity to submit its comments on the OPM proposal to redesign the Federal Employees Health Benefits Program (FEHBP). CNA currently insures five employee organization's fee-for-service plans in FEHBP, covering nearly 600,000 Federal and Postal Employees and annuitants. CNA has participated in the FEHBP for over fourteen years, and is committed to participating in the FEHBP for a fifteenth year in contract year 1991.

We commend the Subcommittee for moving rapidly to address the many important and complex issues raised by the proposal submitted by the United States Office of Personnel Management (OPM). We believe the OPM proposal provides a starting point for deliberation and discussion of the issues of health care costs and health care delivery systems. We appreciate OPM's efforts to provide an outline of important issues which call for judicious and deliberative consideration.

Mr. Chairman, let me briefly preface the text of our remarks by sharing my strong belief that certain basic elements of the FEHB program are sound. If repairs and corrections must be made, decisions must be drawn from the wealth of practical experience available from within the FEHB community. The best way to ensure dissatisfaction with the reform process, and the result, is to ignore the dynamic nature of the FEHB Program and the critical importance of health insurance issues to Federal and Postal employees and their families.

If reforms are necessary, we believe they can be developed best through a partnership that addresses the issues from a knowledgeable position, one built on years of collective experience. Orchestrating that partnership will be difficult -- but, reliance on any less thorough and comprehensive of an approach is a recipe for disaster. Any corrections to the FEHB Program must offer fairness to the 4 million plus active and retired enrollees who rely on your deliberations.

The ever increasing volume and cost of health care services have been identified as a national priority by President Bush. In order to formulate a National Health Care Policy, these issues are currently under examination at the highest levels of the Administration. We believe it is not prudent to change an employee benefits program covering over 4 million plus active and retired enrollees until a national health care policy direction has been established.

CNA, as a major insurer of Federal and Postal employees and annuitants since the early 1970s, brings a sound employee benefits background to a review of the program. Our concerns with the OPM proposal are based on a working knowledge and understanding of employee benefit issues.

The financial arrangements of a health insurance program are many and varied. In the past decade, many employers have self-insured, or reinsured, their health benefits program for several reasons, chief of which are exemption from state mandated benefits, improved cash flow management, and exemption of state premium taxes. The FEHBP is already exempt from state mandates and exemption of state premium taxes can be more easily achieved in other ways than a total overhaul of the FEHBP. Efficiencies in cash flow have already been accomplished by OPM's Letter of Credit arrangement. Since the major incentives for employer self insurance have already been or will be accomplished by the FEHBP, the remaining goal is to reduce costs and minimize risk selection.

Risk Selection

To quote the OPM proposal "Risk segmentation/risk selection occurs when individuals representing the same level of risk congregate in a given plan or option." The sheer number of plans in FEHBP is thought to exacerbate the selection issue. Yet, CNA believes that the number of plans does not in itself impact the cost of medical services. An individual who incurs a five day hospital stay will incur expenses of approximately $4000, whether they are in an HMO plan, an employee-organization plan or a countrywide plan. The majority of this expense will still be covered no matter which Plan or option a person selects. It remains that the primary and continuing problem in health care -- both in the private and Federal sectors -- is the rate of increase in the price and volume of health care services.

Where risk selection does have a specific impact in the FEHBP is in the calculation of the government contribution. Four of the six plans used in the calculation are relatively low in cost. The remaining two high cost plans are the government-wide high option plans, Blue Cross High Option and the former Aetna High Option Plan. These two plans had an enrollment comprised mainly of federal and postal annuitants and, on the average, were older than the average population of the entire group.

The major selection problem in the FEHBP, which was underscored by TPF&C, is the sheer number of and cost of the older population (see TPF&C Report p. 39, Exhibit II-5). The current percentage of annuitants has been shown to be nearly 40 percent of the total FEHBP population. As with the population as a whole, with the "graying of America," these numbers are expected to increase over the next decade.

OPM has proposed to split the Program into two parts: one risk group will be all active employees, and the other will be annuitants. The number of plans has nothing to do with the true selection issue: selection by age.

The FEHB Program, with its wide availability of choices, has managed to produce a network of HMO and fee-for-service plans that many private employers would like to emulate. According to the Congressional Research Study of 1989, "Federal payments for health insurance for the average Federal employee are approximately $1100 per year less than employer payments for health insurance of a typical private sector counterpart." FEHB provides a comprehensive, nationwide network of HMO options, as well as a broad selection of fee for service plans. According to OPM, five fee-for-service plans already enroll 70% of all federal and postal employees and annuitants, mostly at a reasonable cost. If a wide variety of choices produces this result, it seems as if the enrollees are indeed making informed selections.

These five large fee for service plans seem to meet the needs of a broad array of active employees and annuitants. Under the current system, all 4,000,000 FEHB participants have the opportunity to find a plan that satisfies their needs and also not to purchase more than they need or can afford. It is difficult to see how the proposed OPM changes would improve the choices or costs to the participants.

CNA's demographic and marketing research data very clearly adds another dimension to this segmentation of the risk pool: the income of active employees has been and continues to be a major determinant for those enrollees that selected the lower cost employee organization and HMO plans. We know that the salary of a Federal worker generally increases with the worker's length of service. Our research indicates that those plans with lower average ages, and hence age factors, are those that primarily insure lower paid workers. In great measure, these enrollees bought what they could afford, certainly not what they perceived as low benefits. Any revision of FEHBP that attempts to redistribute the relative cost of insuring annuitants will invariably and automatically increase the health insurance costs for those 1 million plus employees who are the least able to afford it.

The most expensive group to insure are the retirees without Medicare coverage. Currently, the cost of their healthcare is spread over a very large group of people. In a separate risk pool; the spread of these costs will be smaller. There are, of course, other options which could be considered as the Subcommittee's oversight proceeds. However, it should be kept in mind that all options to redistribute the cost of providing health insurance to the annuitant population -- under any scenario -- will require either a greater Government contribution or increased premiums for retired employees. Neither scenario for increasing costs for enrollees or for the Government seems politically practical or financially feasible.

Coverage Selection

Most, if not all, FEHB Program plans limit their coverage, usually through deductibles or co-pays (hereinafter "coinsurance") in an attempt to manage costs. In fact, plan design is exactly the job assigned to an underwriter. Controversy is endless as to what extent benefit coverage should be expanded or limited. For the FEHB Program, there exists the anti-competitive contention that "Selection by Coverage" could be avoided if all plans had the same coverage. While this is true, OPM casts this idea in terms of mandating minimum benefit levels for all plans, including HMOs, to discourage movement between plans based on selection by coverage. Many plans rightfully oppose this proposal for the basic reason that their enrollee population selected that plan, knowing its benefits, and because the value represented by those benefits and the corresponding lower price was appealing. Special interest groups such as the mental health lobby, the dental lobby, pharmaceutical lobby, etc., which have an obvious stake in the outcome of specific benefit coverage issues, are constantly pushing their parochial interest for specific minimum levels of mandated benefits. It seems probable that both the annuitants and the active employees could either lose benefits or have to pay higher premiums in separate risk pool arrangements than they do in the current FEHB Plans.

Summary of Selection Issues

Selection in the FEHBP is best viewed as selection of plans based on employment status, e.g. age and income levels, annuitant or active status. Upon review of available industry literature on experience, we find that removal of annuitants from FEHBP and thus further segmentation of the group would not be in the best interest of annuitants or, in the long run, of the Government. Solutions to segmentation of the group through annuitant/active age selection requires a great deal of analysis vis-a-vis what amount of subsidy can be properly allocated on behalf of annuitants to lower paid, younger, active employees currently in lower cost plans. In the Social Security system, the young pay for the old, and the highly compensated individual that could possibly find a better retirement program does not have the ability to opt out.

I do not mean to imply by my statement here today that younger employees in FEHBP should not somehow subsidize the older employees -- with over 24 years of underwriting experience, I fully support that principle of group insurance. Rather, my point is that since for over 20 years a process has been in place whereby lower paid employees (not all of whom are necessarily young) have been able to choose very low cost plans, changing that process should be accomplished with care. We should not reform the program without taking into consideration the economic effect on the 1 to 1.5 million lower paid individuals in the lower priced plans. After all, Social Security is paid for as a percentage of income -- the lower your income, the lower your cost -- FEHBP premiums are not related to income.

The OPM Call Letter for 1991 also proposes to cap a Plan's payments to enrollees with Medicare. By providing a separate risk pool, and restricting payments to providers, Federal and Postal retirees will soon have a health plan almost identical to Medicare. Considering how rapidly Medicare costs have risen in the past decade, it is not likely that this Medicare look alike will prove to be more cost effective than the current program. Annuitants will, in all probability, lose access to many providers of care, since physician selection will be based on Medicare participation.

It also seems likely that the separate retiree plan will have a budget wholly funded by the Office of Personnel Management. As the costs increase, this will result in annual scrambles over funding. In the current Program, benefit payments to enrollees and providers continue uninterrupted even if program expenses exceed the projected costs because the carriers that underwrite the risk are committed to paying the claims regardless of budget battles. No supplemental funding appropriation is usually necessary. If the OPM model is adopted, FEHBP, and especially the retiree pool, will be wholly driven by annual budgetary concerns, and, from time to time, claims payments will be jeopardized.

Claims expenses are the area where we find the major opportunity for the Federal Government to use its purchasing power to obtain FEHBP savings. Over 90 percent of all FEHBP costs are in this category. Initiatives to use leverage in this category are commonly referred to as "cost containment."

All cost containment initiatives have four basic ingredients which interrelate to support a central idea. The central idea is to lower the unit cost and number of units of health care services paid for by the employer, while at the same time assuring that the quality of care received by the enrollee is at a high level. The subsidiary ingredients of cost containment underlying this idea are:

1. Redirection of Care -- having care provided in the most cost efficient setting (e.g. inpatient to outpatient or higher priced provider to lower priced provider).

2. Volume for Discounts -- directing care to quality institutions or providers who, in return for volume, will (a) give discounts on the price of the care; and (b) give contractual guarantees to provide only necessary services.

3. Utilization Review -- determining medical necessity of proposed treatments based on professional medical evaluations with consideration for the cost efficiency of the setting and quality of providers. We believe that unnecessary medical care carries with it the potential for adverse health effects and poor quality care.

4. Control -- redirecting the provision of care through contractual relationships with both enrollees and providers to ensure that both parties abide by respective commitments to receive and provide cost-efficient, quality care.

Thus, Mr. Chairman, we maintain that "what it could be if" ideas are not particularly constructive. A realistic way to accomplish immediate savings would be to draw more effectively on existing market leverage. Pie-in-the-sky creation of an entire new health care market place or the proposed use of non-existent regional carriers tasked with trying to reinvent the wheel (i.e. negotiate new provider arrangements) is counter productive. Existing provider discount and utilization review initiatives are already beginning to take advantage of leverage. Given that discounts aggressively must be enforced, managed, and reviewed to achieve savings, existing carrier efforts can more productively generate savings than an experimental, bureaucratic new program.

Under the current acquisition regulations (FEHBARs), actual disincentives for cost containment have been put in place. The expense of reducing claims costs through utilization review and cost containment initiatives must be lumped together and charged to the general category of administrative expense. Prior to the strict implementation of Federal acquisition regulations to FEHBP contracts, the cost of such initiatives could be, and were, charged-off as claims expenses. This is particularly unfortunate given OPM's current aggressive emphasis on limiting administrative expenses. OPM, which would have carriers increase efforts to reduce claims costs through cost containment initiatives, must recognize that specific administrative funds must be earmarked to accomplish that task.

An objective review of FEHBP claims costs points out obvious opportunities for savings:

- Mandatory Pre-admission Certification and Continued Stay Review
- Mandatory Case Management
- Strong PPO incentives
- HMO experience rating and application of FEHBARs

To quickly and efficiently deliver these savings, current market dynamics should be used, not discarded, and then recreated under an untested, undeveloped, and probably, inadequate model. We believe that OPM's proposal for sweeping reforms to take advantage of leverage will lead to drastic, fundamental philosophically unacceptable results.

Cost of Money

The final opportunity for leverage which we will address is related to the "cost of money." OPM has proposed the possibility of moving the FEHBP away from an insurer-based model to a "self-insured" model and contracting out administrative services. Theoretically the savings to be gained from such a proposal are:

- reduced profit (service charge) for the insurance companies who, by regulation, charge approximately two or three tenths of one percent of subscription income for the risk they assume; and

- cash flow advantages which would accrue to the Government because it would hold all funds until claims were presented for payment.

We believe that the savings suggested by these scenarios may not exist at all and, as with other alternatives represented by OPM, serious problems may develop.

These recommendations would modify the way the FEHBP operates so as to essentially mirror Medicare, replete with ongoing and longstanding administrative problems. Many of these problems are attributable to the fact that the administrative fees offered to operate such entitlement programs as Medicare are inadequate to provide the intensity and quality of service needed. In fact, many major insurance companies have withdrawn from the Medicare/Medicaid market (e.g., Prudential withdrew as a fiscal intermediary effective 1989) because they could not operate profitably in such an environment and did not desire to have the tainted reputation that comes with quality problems.

Conclusion

Mr. Chairman, CNA reiterates its commitment to a partnership approach to any FEHBP reform process. In this way, Congress and OPM can draw on program strengths and on an understanding of the issues that has been built from years of solid and practical experience. We appreciate your interest in our comments and for allowing us to supplement the record with our ideas. As the

Subcommittee proceeds with its FEHBP oversight responsibilities, we stand ready and willing to assist you in your deliberations. Again, thank you for your consideration and concern about proposed refinements to the Federal Employees Health Benefits Program.

FHP, INC.

STATEMENT FOR THE RECORD
ON THE
FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

SUBCOMMITTEE ON FEDERAL SERVICES, POST OFFICE, AND CIVIL SERVICE
UNITED STATES SENATE

APRIL 20, 1990

FHP, Inc. appreciates the opportunity to submit comments for the record on reform of the Federal Employee Health Benefits Program (FEHBP). FHP, Inc. is a 29 year-old federally qualified multi-state health maintenance organization that delivers cost-effective, quality care to over 500,000 members in Southern California, Arizona, New Mexico, Utah and Guam. Almost 50,000 of our members are in the FEHBP system. Further, we are also the third largest Medicare risk contractor in the United States. FHP provides health care to well over 150,000 senior citizens through its risk contracts in California, Arizona and New Mexico.

It is no secret that the FEHBP is in need of serious reform. In light of this fact, FHP has been examining how the current program is structured, how it is operating, and is drafting a detailed policy paper on recommendations for reforming the FEHBP. FHP believes that the managed care industry, and HMOs in particular, should play a major role in helping to solve the problems associated with the FEHBP. FHP's policy document will be finished within the next month, and we will be providing the Subcommittee with a copy upon completion.

FHP, pending completion of our final policy statement, would like to highlight several key issues relating to reform of the FEHBP at this time. This is by no means an exhaustive list. We look forward to discussing these issues and our reform recommendations in more detail with the Subcommittee in the near future.

* FHP believes there should be a minimum benefit standard for all carriers.

* FHP believes there is no need to limit the number of HMOs that can participate in the FEHBP, as in any given market, there are already only a small number of HMO plans from which to choose. In fact, the number of choices available to enrollees tends to keep the costs of the program down because the HMOs and indemnity plans must compete against each other for enrollment.

* FHP believes that a cafeteria plan approach may increase risk segmentation.

* FHP believes that the Administration's proposal to adjust HMO rates "to provide appropriate cross-subsidies between the indemnity plans and HMO plans" should be examined thoroughly to test whether this can ever be done fairly.

* FHP believes that although HMOs are permitted two contract terms to gain at least 300 participants in an FEHBP plan, some operate in rural areas where it may not be possible to achieve this number at all, and they should not be discriminated against because of this. Terminating these contracts would unjustly deny enrollees an alternative to the fee-for-service option.

* FHP believes that federal employees and retirees should be able to choose a health plan during an open season held annually.

* FHP believes that the government contribution based on the weighted average of all FEHBP plans is a reasonable alternative to the "Big Six" calculation, which should be abolished.

* FHP believes that the issue of allowing carriers, including HMOs, to offer a Medigap option to Medicare-eligible annuitants should be examined closely.

* FHP believes that Medicare-eligible annuitants should be able to enroll in a Medicare risk contract and receive the government contribution. The Medicare-eligible annuitant should be able to move between a risk contract and the FEHBP and not lose FEHBP eligibility.

There have been several in-depth studies undertaken in the last few years on reforming the FEHBP, most notably those written by Towers, Perrin, Forster & Crosby (TPF&C) for the Office of Personnel Management (OPM) and the Congressional Research Service (CRS). While we will not address these reports in detail at this point, FHP believes that the TPF&C study was seriously flawed and biased against prepaid health plans.

Today, the foundation of the nation's health care system is being shaken by the spiralling cost of delivering health care services. The FEHBP has not been exempt from that spiral. Any solution to this problem must incorporate many of the cost control techniques which were pioneered by the managed care industry. Wellness programs, quality assurance systems, and utilization review are just a few examples of ways the industry protects its enrollees.

As a final point, the Subcommittee should consider that without HMOs in the FEHBP, the costs would be higher. In the 1988 FEHBP contract year, HMO premiums increased an average of 5-10 percent, as opposed to an average of 32 percent for the fee-for-service options. Further, for private sector employees, conventional insurance plans' premiums in 1989 rose 20.4 percent, while HMO premiums rose 16.5 percent. This represents a 23.6 percent savings over indemnity insurance.

Thank you for your consideration of these comments. Please feel free to contact FHP's Manager of Congressional Affairs, Herb K. Schultz, at (202) 223-5718 if we can be of any other assistance to Subcommittee members and staff.

April 20, 1990

United States
Office of
Personnel Management

Washington, D.C. 20415

In Reply Refer To

Your Reference

MAR 27 1990

Dear Carrier:

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits Program. Specific instructions concerning information required to support requests for rate changes will follow shortly.

To resolve the complications of the contract term that does not conform to the fiscal year and to move Open Season away from the holidays, the next contract term will be 21 months, beginning January 1, 1991. Benefits will remain in place for the entire period. Rates will be adjusted beginning January 1, 1992, for a nine-month period to end on September 30, 1992. The Fiscal Year 1993 contract term will begin on October 1, 1992. No new prepaid plans will be admitted to the Program for the contract term of January 1, 1992 to October 1, 1992 (see 5 CFR 890.203(a)(1)).

In accordance with 5 CFR 890.203(b), requests for the contract term beginning January 1, 1991, must be received no later than May 31, 1990. We urge you to submit your request before the deadline. We will not consider any requests for additional changes submitted after the deadline except those pertaining to proposed rates and based on data not available at the time of submission.

To assure a timely Open Season, we will begin negotiations as soon as possible. Upon receipt of requests for benefit and rate changes, we will operate under a negotiation schedule to ensure that all negotiations (benefits and rates) are completed not later than August 15, 1990.

Guidance on Benefit Changes

Rising health care costs continue to exert an upward pressure on FEHB rates. Because we want to control the extent of cost increases on the Government and FEHB enrollees, benefit change proposals are not encouraged and if made at all should be limited to zero cost increase tradeoffs. However, we will require nondental fee schedules to be adjusted by 7.5%, which equals the rise in medical price inflation for the last available 12-month period. We also are requiring that all fee schedule amounts be rounded to the nearest dollar.

Cost Containment. To ensure that all enrollees and covered family members receive quality care in an efficient manner, all plans are required to include specific cost containment proposals as part of their benefit and rate submission. Your proposals must include provisions for precertification and large case management. At a minimum, provision should be made for (1) verifying medical necessity of treatment or surgery; (2) establishing whether services must be performed in an inpatient setting or could be done outpatient; and (3) for inpatient services, determining the appropriate length of stay (which may involve concurrent review). Your proposals should include substantial incentives for compliance. Large case management should focus on providing lower cost alternatives wherever feasible.

We will be asking you to provide administrative cost information for cost containment initiatives as a discrete category. Data demonstrating savings achieved will be required to support administrative expense allowances.

Mental Conditions and Substance Abuse. In support of the President's initiative to combat substance abuse, we are requiring all fee-for-service plans that have a stand alone inpatient substance abuse program benefit to increase the maximum payment for such benefit by $500. This increased benefit is to be administered under the principles and conditions specified below for all mental conditions and substance abuse benefits.

We are requiring a mandatory case management proposal for mental conditions/substance abuse benefits from all fee-for-service plans. This proposal cannot include an overall reduction in mental conditions/substance abuse benefits. However, the proposal should identify a methodology whereby flexibility can be achieved between inpatient and outpatient services up to the predetermined maximums in order to provide the most effective treatment at the lowest cost. Proposals must be accompanied by estimated savings and administrative costs of performing the required case management.

Dental and Vision Care Benefits. Consistent with our policy for the past several years, we will not consider increases in fee-for-service plan dental schedules for 1991, nor will we accept new dental programs or vision care programs except where they are already an integral part of a prepaid plan's community package.

Coordination of Benefits With Medicare

Every plan needs to have a system in place to ensure that payments under coordination of benefits with Medicare do not exceed the new statutory maximums which physicians may charge Medicare enrollees. We are in the process of negotiating agreements with the Social Security Administration that will enable us to provide you with specific Medicare coverage information.

Review of Disputed Claims

Although OPM will continue to make final determinations on disputed claims, we plan to seek a contract for certain aspects of the review process for experience-rated plans. The costs of the contract will be charged to the experience-rated carriers on a unit cost basis. Detailed information on allowable costs will be provided by your Contract Specialist.

Typesetting of Brochures

This year we are asking all plans to typeset their brochures. Detailed information on allowable costs and scheduling will be provided by your Contract Specialist.

Standard Contract

OPM intends for all carriers that wish to participate in the FEHB Program to sign a standard contract for 1991. You have already received a draft for comment. We will be sending you soon a final version that incorporates the final changes to both the contract and the Federal Employees Health Benefits Acquisition Regulation, which we anticipate will be published shortly. The standard contract will include instructions on supplemental literature.

Submission of Proposals

Proposals submitted by regular mail should be sent to:

Mr. Reginald M. Jones, Jr.
Assistant Director for
Insurance Programs
Office of Personnel Management
P.O. Box 707
Washington, D.C. 20044

Proposals submitted by overnight delivery should be addressed as follows:

Mr. Reginald M. Jones, Jr.
Assistant Director for
Insurance Programs
Office of Personnel Management
1900 E Street, N.W., Room 3415
Washington, D.C. 20415

Please note that these addresses should be used for all future correspondence to this office.

Evaluation of Proposed Benefit Changes

If benefit changes are requested, they will be evaluated in the light of effective utilization and cost control and the economic and health needs of Federal enrollees. Efficiency of administration and the amount of premium needed to support present benefits and requested changes are also important considerations.

Requests for benefit changes must be precisely described and supported by your best estimate of their impact on premium rates. Only changes that are supported by actuarial justification will be considered. Proposed brochure language must also be submitted with requests for benefit changes, including language for a "How Benefits Change in 1991" page. Brochure language must describe benefits, exclusions, limitations, definitions and procedures accurately and clearly, and should be set forth in plain English. Benefit proposal instructions for fee-for-service plans appear in the appendix to this letter. Similar instructions will be mailed shortly to prepaid plans.

Disclosure Policy Under Freedom of Information Act

Any information included in your letter may be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your letter that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure only when a request for information is made. In making our decision, we will consider the justification for non-disclosure submitted with your letter. If we decide that any specific item of information that you believe is exempt is not exempt from disclosure, we will so inform you before it is disclosed.

Sincerely,

RMJones Jr

Reginald M. Jones, Jr.
Assistant Director for
Insurance Programs

Appendix

FEHB Fee-for-Service Plans
Benefit Proposal Instructions

1. Describe the proposal completely and make a brief statement regarding why the change was proposed.

   a) State whether the proposal is a benefit change or clarification.

   b) Be sure to discuss how each benefit area (such as Inpatient Hospital, Surgical, Maternity, Mental Conditions/Substance Abuse, Other Medical, Additional and Dental) is impacted by the proposal.

   c) Discuss impact on any deductibles and coinsurance.

   d) Discuss each change to a specific benefit area separately.

   e) Use a separate work sheet for each proposed benefit change or clarification.

2. Provide your best estimate of the impact on premium rates related to each specific proposal.

3. Describe how we paid the benefit you are proposing to change in 1990. Assuming the proposal is accepted, how will the benefit be paid in 1991? Please provide a narrative description and an example based on an actual claim.

4. Attach to the work sheet describing the change a copy of each page of the 1990 brochure that will be impacted by the proposal. The proposed change should be marked in red on each brochure page.

5. If the proposed change will require a significant change in administrative procedures (such as a new precertification program), describe the necessary change completely. List any new contracts with outside entities that may be needed to administer the proposed change.

   Provide timetables for any new internal administrative procedures and instructions and/or outside contracts to be in place.

ESTIMATES OF PROPOSALS TO CHANGE FORMULA FOR CALCULATING GOVERNMENT SHARE OF FEHB PREMIUM (Non-Postal)

	Self & Family Premium Average	Percentage for Fixing Govt. Max $	Percent of Total Premiums[1] paid by Government for			FY 1991 Savings (millions)
			Employees	Annuitants	Total	
CURRENT LAW	$4,318[2]	60	72	63	67	NA
OPM Alternative #1	$3,523[3]	60	63	55	59	$800
OPM Alternative #2	$3,523[3]	67	69	60	65	$275
Budget Neutral Option	$3,523[3]	72	72	63	67	-0-

(Estimates based on CY 1989 enrollment and premium data from OPM)

1. Percentages based on payments for all enrollees, self only and self & family in CY 1989.

2. Simple average of premiums for self & family for "Big Six" carriers, CY 1989.

3. Enrollment weighted average for self & family premiums of all plans, CY 1989.

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